

**Stepping on Untreaded Waters: A Grounded Theory
Approach to Paediatric Nurses' Experience of Caring for Young
People who Self-Harm.**

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CONTENTS

	PAGE
LIST OF FIGURES & TABLES	iii
DEDICATION	iv
ACKNOWLEDGEMENTS	v
DECLARATION	vi
ABSTRACT	vii
CHAPTER 1. INTRODUCTION	
1.1 Introduction	1
1.2 Self-Harm	2
1.3 Young People Meeting the Challenges of Adolescence	10
1.4 Nursing Education	14
1.5 Nursing People who Self-Harm	20
1.6 Background to Research Setting	28
1.7 Current Study	29
CHAPTER 2. METHODOLOGY	
2.1 Design	31
2.2 Grounded Theory	32
2.3 Literature Review	35
2.4 Sampling in Qualitative Research	36
2.5 Sample Recruitment	36
2.5.1 Nurses	36
2.5.2 Young People	37
2.6 Characteristics of the Sample	37
2.6.1 Nurses	37
2.7 Inclusion Criteria	38
2.8 Exclusion Criterion	38
2.9 Ethical Considerations	38
2.10 Pilot Interviews	40
2.11 Interviews	40
2.12 Data Analysis	42
2.13 Data Management	46
2.14 Reflexivity	46
2.15 Ensuring Rigour	48
2.16 Research Diary	49
CHAPTER 3 FINDINGS AND DISCUSSION	
3.1 Core Category	52
4.1 Main Category: Support Mechanisms	54

4.1.1	Emotions Evoked when caring for people who SH	55
4.2	Support Mechanisms: Personal Support	56
4.3	Support Mechanisms: Professional Support	56
4.3.1	Supervision	57
4.4	Support Mechanisms: Peer Support	59
5.1	Main Category: Knowledge of Self-Harm	60
5.2	Work Experience: Exposure	60
5.2.1	Work Experience: Role Model	61
5.3	Personal Experience: Self	62
5.3.1	Personal Experience: Others	63
5.4	Training	63
5.5	Media	64
5.6	Patient Care	65
6.1	Main Category: Culture	66
6.2	Culture: Nurse Beliefs about Ward Setting	66
6.2.1	Culture: Nurse Beliefs about a Young Persons...	67
6.3	Culture: Attitudes of Professionals towards People...	67
6.3.1	Culture: Attitudes about Perceived Risk of Care	68
6.3.2	Culture: Attitudes about Young People who...	69
6.4	Culture: Behaviour- Challenging Negative Attitudes...	70
6.4.1	Culture: Nurse Behaviour towards Patients	70
7.1	Main Category: Self-Image	71
7.2	Internal Perception: Positive	72
7.2.1	Internal Perception: Negative	72
7.3	External Perception: Peers	73
7.3.1	External Perception: Public/Parents	73
7.3.2	External Perception: Patients	74
8.1	Principal Category: Type of Nurse	75
8.2	Type of Nurse: Personality	76
8.3	Type of Nurse: Interest	77
8.4	Type of Nurse: Training	77
9.1	Principal Category: Catch 22	79
9.2	Catch 22: Role of Friend	79
9.3	Catch 22: Role of Safe-Keeper	80
10.1	Principal Category: Being in the Picture	82
10.2	Being in the Picture: Being with	83
10.2	Being in the Picture: Talking	83
11.1	Model of Support Resources	85
12.1	Confirmability of the Present Findings	91

CHAPTER 4	IMPLICATIONS OF FINDINGS AND CONCLUSIONS	92
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REFERENCES	98
Appendix 1: Nurse information sheets	128
Appendix 2: Nurse questionnaire	130
Appendix 3: Research protocol	132
Appendix 4: Information sheet, participant consent, parent/guardian consent form & letter to parent/guardian	135
Appendix 5: Summary of Participants	139
Appendix 6: Consent form	141
Appendix 7: Interview guide	143

LIST OF FIGURES & TABLES

Figure 1.	Example of line by line open coding	42
Figure 2.	Example of a memo	44
<i>Table 1.</i>	<i>An overview of the analytical process of the present study</i>	<i>44</i>
Figure 3.	Architecture of categories	52
Figure 4.	Main category: Support Mechanisms	54
Figure 5.	Main category: Knowledge of Self-Harm	60
Figure 6.	Main category: Culture	66
Figure 7.	Main category: Self-Image	71
Figure 8.	Principal category: Type of Nurse	75
Figure 9.	Principal category: Catch 22	79
Figure 10.	Principal category: Being in the Picture	82
Figure 11.	Resources available to nurses to assist them to cope with the experience of caring for young people who self-harm.	88
Figure 12.	Model of Support Resources: Means of increasing resource availability to facilitate nurses' sense of control and safety.	88

DEDICATIONS

To my parents, Michael and Phyllis McGlynn

'Thank you for leaving no candle unlit in Dublin! Your love and support constant as always '

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'Without you this year would have felt a much steeper hill to climb...if that's possible! You excelled the terms of your contract – it's up for renewal if you're up for the challenge!'

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'This thesis has been composed by myself
and all work contained herein is my own'

Tracy A. McGlynn

ABSTRACT

Aim: The present study explores paediatric nurses' experiences of caring for young people who self-harm. The purpose is to identify the impact of caring for this patient group and the potential implications this has for patient care.

Background: It is estimated that between 20,000 and 30,000 young people present to hospitals in the UK with self-harm injuries each year. The current literature reveals that healthcare workers based in psychiatric and accident and emergency settings experience a range of negative feelings when caring for adults who self-harm. Self-harm can challenge the value system of a nurse and raise issues regarding whether someone is deserving of care. There is a scarcity of literature exploring paediatric nurses' experience of caring for young people on a medical ward.

Method: A grounded theory approach was undertaken to meet the aims of this study. Eight paediatric nurses working in a hospital in the Scottish Highlands took part.

Findings: The findings revealed one core category, 'Stepping on untreaded waters', which represented nurses' sense of uncertainty. This category related to four main categories which described: the use of support mechanisms; knowledge of self-harm; nursing culture; factors which influence a nurse's perception of being a 'good nurse'. The core and main categories were related to three principal categories which were all formulated into a Model of Support Resources.

Implications: The need for a sensitive, creative approach when introducing further education and training to nurses is critical, given the climate of change in nursing education.

INTRODUCTION

1.1 Introduction

Self-harm is one of the leading reasons why young people attend hospital (Hawton et al., 2006). It is a maladaptive coping mechanism or means of communicating distress but is often confused with being indicative of suicidal behaviour. Although the young person's intention is often to stay alive, it is significantly related to suicide. A person is 18 times more likely to commit suicide if they have a history of self-harm (Ryan et al., 1997). The Mental Health Foundation and The Camelot Foundation launched a national two year inquiry into this phenomenon, which resulted in the recent publication of a report entitled *Truth Hurts* (National Inquiry, 2006). In this report young people who self-harm offered valuable insights and guidance on how to best direct patient care. In that same year, the National Institute for Clinical Excellence (NICE, 2004) published guidelines on the short-term management of patients who self harm and recommended the use of qualitative research to gain greater understanding of this problem.

Research suggests that many people caring for those who self-harm experience a negative emotional response (Anderson et al., 2003; Gabbard & Wilkinson, 2000; Rayner et al., 2005). Studies have shown that people who self-harm are aware of these negative attitudes and beliefs, which sometimes manifest in overt negative behaviour being directed at them (Bohus et al., 2000; Hemmings, 1999). If a patient perceives a negative response from others, it can trigger further episodes of self-harm (Alexander & Clare, 2004; Connors, 2000; Pembroke, 1996). This has implications for a person's willingness to engage with healthcare services in the future (Ryan et al., 1998). As many young people self-harm repeatedly and are largely found to do it impulsively, there is a very real risk that a young person may harm themselves so severely that failing to seek medical care could ultimately lead to their unplanned death (Crawford & Wessely, 1998).

Some research has explored healthcare workers experiences of caring for adults who self-harm in an emergency or psychiatric setting (Anderson et al., 2003; Clarke & Whittaker, 1998) but there is little mention of paediatric nurses experiences of caring for young people in a medical setting. This study aims to explore this issue.

This chapter looks at the current literature on self-harm, the challenges facing young people at a period of transition in their life, nursing education and finally the nurse's experience of caring for people who self-harm. Quotations from young people are included to provide a richer sense of detail.

1.2 Self-Harm

Hawton et al. (1998) explains that 'deliberate self-harm' is viewed as a medical condition within health services and society generally. The word 'deliberate' in this context has been rejected by many service users because of perceived negative and judgemental connotations. It implies premeditation and wilfulness and the description 'self-harm' is preferred by those who engage in the behaviour (Pembroke, 1996; Pembroke, 2000; Spandler, 1996). The literature contains many other terms to describe self-harm including: delicate self-cutting, self mutilation, self-injury, autoaggression and suicidal gestures (Favazza, 1998). These different labels describe a number of behaviours. It can involve cutting, burning, scalding, banging or scratching one's own body, breaking bones, hair pulling and the ingestion of toxic substances or objects (National Inquiry, 2006:5). A number of socially sanctioned behaviours could be viewed in terms of self-harm, such as having a high risk job or hobby like car racing; also over-exercising, severe obesity, body piercing, tattoos and smoking to name some (Favazza & Rosenthal, 1993).

Most self-harm presentations involve overdoses rather than self-injury (Hulten et al., 2001). Many young people who self-harm make repeated cuts on their skin using a sharp material, such as a razor blade, piece of glass, a needle or a pair of scissors. Burning

skin, punching and scratching the body are other forms of self-harm (Machoian, 2001). Common areas that are injured include the arms, wrists, ankles and the lower regions of the legs. However, the young person may chose a less obvious part of their body to harm, such as in the armpits, under the breasts, inner thighs, abdomen and base of feet (Derouin & Bravender, 2004). Injuries tend not to need treatment (Schwartz et al., 1989). Hawton et al. (2006) found that the most frequent multiple method of self-harm reported was taking an overdose as well as cutting. The authors listed common methods of self-harm: self-cutting; jumping from a height; running into traffic; hanging and self-battery.

Hawton et al. (2006) estimate that between 20,000 and 30,000 young people present to hospitals each year in the UK because of self-inflicted injuries and overdoses. Self-harm is one of the leading cause of hospital attendance among young people. Kreitman and Schreiber (1979) identified that there was a significant increase in hospital presentations of self-harm episodes in the 1960's and 1970's. Incidence rates remained stable throughout the 1980's (Sellar et al., 1990) but in recent years a further upward trend has occurred particularly among young females (O'Loughlin & Sherwood, 2005). The average age of onset is believed to be twelve years with as many as one in twelve young people engaging in the behaviour (National Inquiry, 2006).

It is, however, difficult to estimate the true prevalence rate of self-harm as hospital attendance figures reflect only those who require treatment (Mental Health Foundation [MHF] 1997; Pembroke et al., 1998). Given the stigma that is often associated with self-harm (Vivekananda, 2000) people may disguise injuries they have acquired by claiming that they are accident prone (Barstow, 1995). Hawton et al. (2006) conducted a study exploring self-harm in a sample of over 6,000 schoolchildren aged fifteen and sixteen years in the UK. They found that only 12% of young people who self-harm attended hospital as a result. Their findings illuminate the difficulty that exists in establishing a true estimate of prevalence rates based on hospital presentation figures. They propose that these figures reflect only the tip of an iceberg when it comes to understanding the

true extent of this problem.

The literature reveals a change in the demographic picture of an individual who self-harms (Derouin, 2004). Self-harm was seen as mainly related to young people with schizophrenia, clinical depression, obsessive compulsive disorder, borderline personality disorder and anxiety disorders. It was also reported among young people who had suffered abuse, misused chemical substances and had been incarcerated (Bohus et al., 2002; Dallam, 1997; Favazza, 1998; Machoian, 2001). Instead the current profile depicts a young person without a history of any of these issues. They often appear successful, extraverted, and are well liked (Machoian, 2001). Their self-harm is often kept secret from family and friends and may continue for years before it impacts on their lifestyle and becomes known to others, if in fact it ever does (Derouin & Bravender, 2004).

There are approximately one third of a million young people living in the UK who have a learning disability (Emerson et al., 2001). Most research in this area takes a medical model perspective and considers self-harm as a behaviour that is associated with a syndrome rather than a response to emotional distress (Collacott et al., 1998). Wisely et al. (2002) assert that between 8-15% of young people with a severe learning disability who are living in an institutional setting self-harm. They estimate the figure to be anywhere between 2-12% for those living in the community. Research exploring self-harm among people with mild to moderate learning disabilities is scarce. This prompted the Mental Health Foundation (2005) to undertake an inquiry which found that young people with learning disabilities are just as likely to experience the same range of mental health issues as other young people but are more prone to anxiety and depression. A high incidence of self-harm was noted, as was the lack of detection and intervention of problems in this population group.

People belonging to an ethnic group are more likely to self-harm if this particular ethnic group are a minority in their community (Neeleman & Wessely, 1999). This is

considered a risk factor for people who commit suicide.

Hawton et al. (2003) found that females aged twelve years are eight times more likely to self-harm than their male peers. However, the prevalence rates of females who self-harm dramatically decrease by the time they are eighteen years, with females being twice as likely to self-harm than their male counterparts. They also noted that hospital presentation of self-harm is rare among the prepubescent population. Hawton (1986) points to the earlier onset of puberty in females as playing an important role in the striking gender difference that exists at twelve years. Males are also more likely to externalise their problems in the form of aggressive or delinquent behaviour than females (Garofola et al., 1998). Many young females tend to equate listening with a caring relationship. If a person is perceived not to be actively listening to them, they may then interpret this as the other person not caring (Brown & Gilligan, 1992) which can lead to further self-harm in an attempt to re-engage a caring response (Machorian, 2001).

According to research, at the beginning of this decade the public's attitude towards self-harm remained negative (Vivekananda, 2000). There are many myths which surround the area of self-harm (National Inquiry, 2006). Some people view those who engage in this behaviour as manipulative and attention seeking. Others may perceive self-harm as a means of gaining pleasure, as a group activity or associate it with membership of a 'Goth' culture. It can also be viewed as a failed suicide attempt or be seen as indicative of a borderline personality disorder. Most young people report feelings of shame and guilt:

There are plenty of ways to get attention, why cause yourself pain? And if someone's crying for help, bloody well give them it, don't stand there and judge the way in which they're asking for it.

(young person quoted in Truth Hurts, National Inquiry, 2006:27)

I am of the opinion that current society rejects self-harmers and is mostly repulsed by them.

(young person quoted in Truth Hurts, National Inquiry, 2006:28)

People often link self-harm to suicide but for me it was something very different: it was my alternative to suicide; my way of coping even though sometimes I would wish that my world would end!

(young person quoted in Truth Hurts, National Inquiry, 2006:28)

In 2004, the 'See Me' campaign was launched in Scotland to challenge the stigma associated with mental illness. Young peoples' attitudes towards each other were addressed through the creation of a fictional character called 'Cloud Boy' whose storyline recounted his experience of self-cutting. Another television advertisement campaign was aired by The Young People Campaign in 2005, which involved young people talking about their experiences of stigma. Hawton et al. (2006) found that stigma associated with self-harm was the main reason young people failed to use helplines and services offered.

When a person self-harms the brain releases neurochemicals known as endogenous opioids, similar to drugs like opium. They can produce a state of calmness and well-being (Smith et al., 1998). Bohus et al. (2002) explain that the act can be 'painless' and lead an individual to fixate on the analgesic aftermath, creating an almost addictive like quality to the behaviour. There is no evidence that the behaviour is addictive but the biological component suggests that the person may need to engage in greater degrees of harm to derive the same effect (National Inquiry, 2006).

Cutting in small amounts doesn't usually help me to relieve pain, it used to, but I've done it for so long I need to cut a lot to help it now.

(young person quoted in Truth Hurts, National Inquiry, 2006:25)

The neurochemical serotonin is related to impulse control. When a person is under stress, levels of this neurotransmitter are lowered making risk taking behaviour more likely (New et al., 2005). Self-harm is not usually the result of premeditation but reflective of impulsivity (Apter et al., 1993) and Hawton et al. (2006) found that 40% of young people thought about the act for less than an hour before engaging in it.

In addition to feeling preoccupied with the behaviour, many young people report feelings of urgency, anxiety and uncontrolled impulses; as well as having racing thoughts (Cavanagh, 2002). During times of severe stress and anxiety, self-harm can depersonalise the situation (Dallam, 1997).

As well as the neurochemical implications of self-harm, some psychological models propose that people engage in this behaviour because of an inability to adequately access support systems. Wainwright and Calnan (2002) explain that social support has the potential to benefit an individual and enable them to feel empowered to cope with stressors in their life. However, social relationships demand a level of reciprocity and if an individual has low self-esteem, is depressed or anxious and has only limited resources available to them they may not be able to engage in this social process. This may result in a person feeling isolated and more likely to self-harm. As discussed below, a young person may not identify that they have a problem or may not have the language available to them to articulate their experience to others. As a consequence they may be left to cope with their difficulties with poor or inappropriate coping strategies.

Favazza (1998) explained that young people trying on new roles can adopt the role of a 'self-harmer' because a peer has revealed to them the sense of relief it brought. This can spread among groups and is known as the 'contagion effect'. Exposure to violence through the media can lead a young person to turn violence upon themselves if they do not filter the information properly and have low impulse control. Those who are exposed to violence may perceive the world to be a violent place to live and conclude that

violence is the best way to resolve issues (Derouin & Bravender, 2004).

Interesting findings emerged from a qualitative study exploring behaviour patterns leading up to self-harm in adults. They proposed the existence of two potential pathways that can lead to self-harm. The 'Springer' recognises an increasing build up of tension and uses self-harm to relieve these unpleasant feelings. However the 'Switcher' has a more immediate pattern in that they become fixated on self-harm all of a sudden and do not identify a build up of emotions. The 'Springer' group found talking to someone helpful and benefited somewhat from stress reducing strategies, such as relaxation. The 'Switcher' group actually found relaxation exercises exacerbated their distress, as they felt further out of control and did not find talking to be helpful in delaying or preventing an episode of self-harm (Huband & Tantam, 2004).

A large scale study was undertaken to explore self-harm in a sample of over 30,000 young people from seven different countries. Contributing factors that led a young person to self-harm included: being the victim of school bullying; difficult relationship with parents; academic pressure; parental divorce; bereavement; unwanted pregnancy; experience of abuse (physical, emotional or sexual); concerns regarding sexuality; issues related to race, culture or religion; low self-esteem and rejection (Madge et al., 2004). Self-harm seems to be a complex issue that is the result of a culmination of experiences rather than one definitive cause (Fox & Hawton, 2004).

My emotions can vary rapidly and be very intense. In an emotionally charged situation, I will either during or shortly after harm myself. I'm not good at dealing with emotions or communicating mine to others.

(young person quoted in Truth Hurts, National Inquiry, 2006:22)

I don't deal with daily stress well, so when extra events occur however big or small, my tension levels rise, resulting in my needing a 'release'. Self harm has proven to be most successful in doing this.

(young person quoted in Truth Hurts, National Inquiry, 2006:22)

In a ten year study exploring characteristics and trends of young people presenting to hospital after self-harm it was found that the largest number of incidents occurred on a Monday, with the least number of episodes reported on a Saturday. It was also found that there was a dramatic decrease in self-harm presentation during school holidays, which implied that school stress could be a motivating factor in the behaviour (Hawton et al., 2003).

A lack of problem solving skills has also been cited as a contributing factor (Hawton et al., 2006). Lazarus & Folkman's (1984) transactional model on the process of coping describes how an individual appraises threat and the availability of resources as a means of perceiving their ability to cope. The model outlines three perceived outcomes that may arise from a situation: irrelevant, beneficial or harmful. If a person perceives their coping resources as being adequate to meet the perceived challenges, they are less likely to feel stressed (Wainwright & Calnan, 2002). Emotion focused coping strategies involve the individual dealing with the reaction to a stressor rather than the trigger though avoidance, denial or humour, for example. Problem focused coping strategies lead an individual to actively seek out a solution to the underlying problem. For example, the individual may seek out someone to speak about the problem to try and deal with it. Carver et al. (1993) explain that problem focussed coping strategies are more effective. Linehan et al. (1987) found that people who self-harm have a tendency to engage in passive coping approaches, which is more reflective of emotion focused coping strategies.

People may find physical pain easier to deal with than their emotional distress and bleeding has been described as an important outcome, especially for those who are

unable to cry tears or wish to cleanse their body of evil (Soloman & Farand, 1996).

The strongest predictor of self-harming behaviour is if the person has a history of self-harm (Sakinofsky, 2000). Hawton et al. (1996) reported that 70% of young people presenting to a hospital with self-harm admitted to engaging in previous acts of self-harm which had not led them to seek care. With regards to overdoses, O'Grady (1999) highlighted the danger of paracetamol ingestion, as it can lead to liver damage and ultimately death. Hawton et al. (2006) pointed out that if a young person does not feel confident to seek medical help after taking paracetamol they may end up with severe liver damage, compounding the problems already experienced. As repetition is common it increases the risk of accidental suicide in the event that the individual underestimates the lethality of the method or fails to seek appropriate care when required (Zahl & Hawton, 2004).

In summary, there are many forms of self-harm behaviours, with overdose being the most common one to lead to hospital presentation. Self-harm allows a young person a coping mechanism to deal with their emotional distress. People can learn to use more adaptive coping strategies than self-harm. However, preventing a person from self-harming without an effective alternative in place can reduce a person's sense of control and trigger further incidents of self-harm. There is a biological component to self-harm which may make finding a similarly effective coping mechanism difficult. There are also a number of myths which fuel the stigma associated with self-harm which are thankfully being addressed through a number of public awareness campaigns.

1.3 Young People Meeting the Challenges of Adolescence

Studies have shown that young people admitted to medical units are sometimes viewed as difficult (Boyes, 1994; Burr, 1993; Foote, 1997). A young person's difficulty in communicating their feelings may reduce the effectiveness of professional interventions and maintain stigmatising beliefs held of them (McGaughey, 1995). Depression in young

people can manifest itself as boredom, irritability and anhedonia rather than sadness. Anxiety, aggressive behaviour and substance misuse frequently occur alongside depression (Shaffer et al., 2003). If the young person is not identified as having these problems because of this lack of communication, it follows that they are less likely to be perceived in a favourable light.

At the turn of the last century, G. Stanley Hall (1908) described adolescence as a time of storm and stress, which was characterised by conflict and mood swings. Years later, Offer et al. (1988) argued that the majority of adolescents are competent individuals who are not experiencing deep emotional turmoil. Young people are faced with physical, emotional, cognitive and social changes as they make the transition to adulthood. This does not necessarily have to be a time of storm and stress but it can lead to confusion, anxiety, stress and depression in young people (Violato, 1998).

Erikson (1950, 1968) described 'identity versus confusion' as the fifth stage of his psychosocial theory of development that occurs around the time of adolescence. It is a time when an individual focuses on personal issues which explore their sense of who they are and where they are going in life. The gap between the security of childhood and the autonomy of adulthood is termed 'psychological moratorium'. During this time a young person experiments with a number of different roles and identities that are available to them in their culture, searching for acceptable behaviour, coping mechanisms and support systems. If they are able to resolve these conflicting identities, they can emerge with a new healthy sense of self. However, 'identity confusion' occurs when the young person is unable to do this, which can lead the individual to withdraw and isolate themselves from others; alternatively they may lose their identity among others. Erikson's (1950) theory of adolescent crisis highlights the need for a supportive family system and a good sense of self-esteem for identity development (Webb, 2002).

Santrock (1997) explains that identity formation is not exclusive to the stage of adolescence. Instead, it begins in infancy with attachment to significant others and the development of a sense of self and independence, culminating in older adulthood when an individual reviews their life. Making sense of all the components of identity can prove a lengthy process which demands many negotiations and confirmations of various roles.

Stack (1991) describes two forms of identification with others: vertical and horizontal. In the former, the individual relates to a celebrity or somebody of a perceived higher status than themselves. The latter, involves a person relating to someone who is perceived to be similar in some way such as in age, type of problems experienced etc. These processes of identification are thought to account for the increase in self-harm after the depiction of fictionalised portrayals in the media (Hawton et al., 1999c; Schmidtke & Hafner, 1988). Young people have been seen to be particularly vulnerable to this process as illustrated by Sargent et al. (2002) when they established strong links between adolescents viewing characters smoking tobacco in films and their subsequent engagement in this behaviour.

Derouin and Bravender (2004) describe the stress of balancing independence from parents with dependence on them. This can be an awkward time for a young person, which is not helped by misunderstanding and unclear expectations from their parents. Many young people lack the emotional and cognitive skills that are required to cope with stressors and as a result may resort to destructive behaviours as a means of managing their stress (Bravender, 2002). Thomson et al. (2002) also described how self-harm may be a response to coping with stress experienced during transitional stages of life. Anderson et al. (2004) propose that a young person may experiment with the role of 'self-harmer' as a means of coping with stress. Goffman (1959) described how a person can become committed to a role because it becomes integrated into a sense of self. Thus self-harm may become a part of a person's self-image as it is seen as a useful coping strategy in the face of adversity.

Societal norms influence behaviour by providing a framework of rules specific to that culture. An individual becomes socialized to the rules of their society, which influences their perception of what is considered normal and acceptable behaviour. These norms will differ across cultures and impact on the way different acts of self-harm are interpreted (Redley, 2003). Negative emotional expressions are tolerated less as an individual ages, for example, an infant having a temper tantrum is expected to learn to control these feelings as they mature. Similarly, a young person is expected to comply with societal expectations reflective of their age (Dreitzel, 1973). As Pilgrim & Rogers (1999) describe: 'By young adulthood, those of us who act either immorally, incompetently or irrationally will be deemed by others as to be either bad or sick'. Anderson et al. (2004) found in their clinical experience that young people who self-harm are seen as 'deviant'. Behaving outside socially acceptable norms can lead to being labelled as mentally ill. It can be confusing and challenging to others when an individual's behaviour moves outside patterns of perceived normality (Dreitzel, 1973). Thus self-harm may not be seen as a coping strategy that is important to the individual or in fact an integral part of their identity (Anderson et al., 2004).

Hawton et al.'s (2006) large scale school study found that 15% (903) of young people had thoughts about self-harm in the previous year but had not acted on them. A quarter of these young people did not believe they had a problem. Saunders et al. (1994) similarly found that just over half of the young people in their study who self-harmed recognised that they needed help. Not only may young people have difficulty recognising a problem behaviour, they may also have difficulty communicating their difficulties. Hill (1995) described the isolation that young people experience as a result of not being able to convey their despair in words and the limitations of being left to express their distress through their behaviour.

Hawton et al. (2006) raised an interesting point that although thoughts of self-harm can indeed lead to engaging in the behaviour, it may also be the case that thoughts of self-harm are reflective of a time in a young person's development in which the concept of one's own mortality becomes apparent. It follows then that these thoughts of self-harm are not automatically indicative of something being wrong in the young person's life; hence this may in part explain why not all young people believed they had a problem.

In summary, young people face a number of challenges as they progress through their adolescence. One important aspect of their development is identity formation. Young people adopt a number of different roles which allows them to form a unique sense of self. At this time they are vulnerable to adopting roles which encompass maladaptive coping strategies as they encounter problematic issues in their life. As young people may have difficulty articulating their distress, they may experience feelings of isolation. Their inability or unwillingness to communicate their experience may also serve to maintain stigmatising beliefs in the view of others who perceive them to be difficult.

1.4 Nursing Education

Nolan et al. (1998) described the tendency in the past for student nurses to be treated as an 'extra pair of hands' by staff who were grateful for the additional help but often failed to acknowledge students' learning needs. This left many nurses ill equipped to adapt to changes occurring in an evolving healthcare system, which led to increased stress and lowered morale. It also acted as a catalyst for a number of nurses to leave the profession (Kendrick & Simpson, 1992). The Royal College of Nursing (RCN, 1985) recognised that nursing education needed to be addressed and published recommendations which subsequently led to 'Project 2000 - A new preparation for practice' (UKCC, 1986).

Project 2000 saw the hospital-trained apprenticeship model replaced with an academic model integrated into a university setting. It was introduced in an effort to produce nurses whose practice was guided by evidence based research (Jasper, 1996). Nursing

students no longer held hospital employee status (Ghazi & Henshaw, 1998) as they became integrated into higher level education. The UKCC (1986) stipulated that nurses who had received qualifications prior to these new initiatives were able to convert to higher level qualifications with additional training.

Amos (2001) found that nurses who are taught critical appraisal skills are more confident at questioning senior personnel and placed more value on research than their colleagues who have received a more traditional educational approach. However, this training has also received much criticism for creating nurses who are ill equipped with practical skills on qualification (Clark et al., 1997).

Increasing demands placed upon nurse educators has resulted in them not having enough time to fully inform ward staff about educational developments in the nursing profession. This has led to senior nursing staff having to mentor student nurses without proper knowledge of their course requirements (Andrews & Chinton, 2000). Confusion surrounding placement outcomes, course paperwork, and most importantly whether students are 'safe' to carry out patient care without observation have all been reported (Clark et al., 1997; Elkan et al., 1993).

Students themselves have said that the length of their placements left them with little time to learn practical skills and, in the absence of a mentor, felt it was difficult to achieve their learning outcomes. Students were viewed as 'burdensome' or a hindrance because staff did not feel confident to allow them to assume responsibility (White, 1996). As a consequence of these perceived negative attitudes, students were left feeling stressed and fearful of making a mistake (Power, 1996). Bick (2000) reported that newly qualified nurses feel extremely vulnerable and overwhelmed on qualifying and are in need of support.

Barton (1996) also highlighted an anti-academic culture within the nursing profession which meant this new approach to learning was met with resistance. Evidence of which can still be seen in present day nursing practice and can manifest itself in the form of professional jealousy (Gillespie & McFetridge, 2006). Project 2000 received much criticism in widening the gap between theory and practice (Wakefield, 2000).

In response to these concerns, a number of policy documents such as Fitness for Practice (United Kingdom Central Council, 1999) have since been introduced. This led to the introduction of new curricula in Scotland in 2001, which reflects a common theme that nursing is a practiced based profession (Gillespie et al., 2006). The Nursing Standard is a weekly nursing publication owned by the Royal College of Nursing. It offers insight into campaigns and topical issues of concern for nurses. A current campaign advertised on their website is 'Charter for change: fighting for a better deal for students'. Two items on their agenda include a call for at least one hour a week protected time with a mentor and a call for a greater level of respect to be shown to them (RCN, 2006).

Horns (2006) wrote about the value of rituals in nursing. A ritual is described as a repetitive behaviour that does not have a direct overt technical effect. For example, when a nurse finishes her shift, she checks each of her patients and provides the next nurse on duty with an account of their medical status. This is termed 'handover'. It is a ritual of many nurses to check their patients immediately following 'handover' as they begin their new shift. This is not a mandatory protocol as the patients have just been assessed. Horns likens rituals to a language in that they symbolically represent values and cultural orientations of a 'good nurse' and are only meaningful to those who are able to understand it. Rituals allow a novice nurse to feel less anxious when she is learning to overcome her inexperience. Rituals encourage group cohesion; they inform practice and allow transfer of implicit knowledge to others (Carper, 1978).

Horns (1996) explains that as rituals are often not the result of evidence based practice, they can cause conflict between the traditional clinical nurse and the nurse researcher. Rituals can provide an experienced nurse with a sense of stability in times of change but nurses can also become over-reliant on rituals and be less embracing of change as a result. A newly trained nurse may not fully appreciate the core value of rituals and the importance more experienced nurses' place on them (Strange, 1996). These contrasting perspectives may lead to an imbalance in providing a standardised practise of nursing care (Horns, 1996).

Regan (1998) described the implementation of Clinical Effectiveness Initiatives in nursing in 1996. The aim was to move nursing practice away from a 'trial and error' or 'well, we've always done it this way' approach. The small body of research that has explored service users' experiences of healthcare provision after an episode of self-harm highlights an urgent need to standardise care through evidence based practice.

Pravikoff et al. (2005) explored evidenced based practice among a sample of American nurses. Evidence based practice involves critically reviewing the current research evidence to guide clinical practice. They found that nurses are more likely to ask a colleague their advice than trust printed resources when needing to make a decision, findings which were supported by Thompson (2001). The Internet and World Wide Web were found to be more popular than bibliographic databases. Ease of use and retrieval success were cited as important factors in this choice but the authors warned about the need to judge the credibility of the findings. Technological advances that have evolved over the last ten to fifteen years have led to nurses being more proficient at electronic resource retrieval if they were educated after 1990 (Tanner, 2000). This research applies to American trained nurses but it follows that if Scottish nurses were similarly not accustomed to using information technology during their training, they are at a disadvantage compared with those who did. Pravikoff et al. (2005) concluded that nurses are not ready yet for evidence based practice because of a lack of knowledge and

skills in accessing information resource, time constraints and, most importantly, a lack of value placed on research itself.

Student nurses have highlighted the benefits of peer support when they described the sense of unity and understanding that came from emotionally supporting each other (Campbell et al., 1994). Slavin (1996) encouraged sharing experiences through group discussion as it can lead to 'cognitive elaboration', a deeper understanding of something through the act of detailed discussion. This approach is encouraged in adult learning approaches. Spouse (2003) also demonstrated that peer support can facilitate learning by sharing experiences in a small group and reflecting and relating it to others' experience.

Intrapersonal intelligence involves being self-aware and identifying ones own feelings and recognising them in social behaviour (Gardner, 1993). Nurses use this form of intelligence when they relate to a patient on an empathic level and they try to gain an understanding of their experience, with the aid of counselling skills. However, Burnard (1994) emphasised the importance of nurses engaging in self-reflective practice to ensure that they are aware of their own prejudices and values so these do not infringe on their interaction with the patient.

The nursing profession has moved from a medical model to a biopsychosocial model of care which involves meeting the physical, psychological, social and spiritual needs of patients. This model encourages the development of less formal patient-professional relationships (Benner, 1984). This relationship involves open communication (Savage, 1990) and rapport building but it also leaves the nurse vulnerable to feeling emotionally overwhelmed (Sand, 2003).

Emotional labour occurs when an individual tries to control instinctive emotions such as frustration, annoyance or disgust. If a nurse feels that her emotional reaction is not appropriate to convey she can attempt to control, manage or alter it. This may prove

easier for some nurses than others and certain circumstances may require intense emotional involvement. If a nurse finds it particularly difficult to engage positively with a patient, the emotional labour involved is likely to leave her feeling emotionally exhausted or drained (Hochschild, 1983).

Fayerweather (1959) described culture as being an independent variable that is brought into the environment through membership and its existence can be seen in the overtly expressed beliefs and behaviour of those within that environment. Knight (1998) found that professional socialisation through experience and education leads to individuals ascribing to general attitudes and values regarding nursing and education. Attitudes that are reflective of the wider social context were also found to be expressed in the work culture. Shared understanding of these values and assumptions allows a collective appreciation of social rules and norms which directs and explains behaviour (Morgan, 1986). Marris (1985) explains that this implicit understanding results in individuals being able to arrive at unconscious decisions about the way they act. Change that is introduced to a culture threatens this implicit understanding that enables a person to feel confident about their actions and leads to a sense of loss.

Cognitive dissonance can be experienced by nurses when the focused academic ideal fails to meet the reality of the flexible clinical setting (Meyer & Xu, 2005). Festinger's (1962) cognitive dissonance theory asserts that people experience discomfort when there is a difference in the world as one believes it to be and the way it is found. This discomfort or dissonance occurs because beliefs are threatened, which motivates the individual to disconfirm or challenge their beliefs. In the absence of reflective practice, a nurse may become disillusioned with clinical work or alternatively devalue the academic ideal as well intentioned but irrelevant (Meyer et al., 2005).

Cognitive dissonance can be a positive experience in that it encourages critical thinking but without a forum to explore dissonance, it can lead to stress (Cronqvist et al., 2001).

One means of addressing this issue is offered by the Neuman Systems Model (2001). It has three levels of intervention. The primary stage involves academic exposure followed by discussion exploring issues, such as why student nurses may feel they are wasting their time with research when the nursing role has such a practical component. The second stage occurs when the nurse has worked in a clinical setting and may have experienced dissonance, for example the nurse may have observed someone provide care viewed as less than ideal. The final stage, the tertiary stage, relates to adapting to the work environment and being aware of further dissonance through the use of a small reflective group. It is considered important to highlight skills and knowledge that have been gained through experience and may be difficult to overtly teach.

In summary, nursing education has progressed from a practical based approach to one that places greater emphasis on evidence based care. This has resulted in a transition that has integrated nurse training into a university setting. The research orientation it engenders aims to foster an appreciation in nurses of the importance of research led care. The intention is to offer a standardised approach to all patients in regards to meeting their psychological as well as physical needs. The new curriculum introduced since Project 2000 (1986) has seen nurses receive their training in universities since 1996. This has meant that nurses early in their nursing career are working together on wards with staff who have received traditional training which has led to tension and conflict among these two staff groups.

1.5 Nursing People who Self-Harm

Hamilton & Cook (2000) described a number of barriers in providing patient care to adults who self-harm. Participants talked about staff shortages, a lack of clinical space to allow privacy when carrying out assessments, a lack of training and a low priority given to adults who self-harm by psychiatric services.

Medical staff may underestimate a young person's actual suicidal intent because young people are not always aware of the lethality of the method of self-harm they employ. For example, a young person may ingest a low dosage of medication with the intention of ending their own life but be unaware that the levels are insufficient to complete an act of suicide. Staff may perceive the young person to be attention seeking and not recognise the seriousness involved (Kennedy et al., 2004). Hill (1995) highlighted a number of adult misconceptions: a young person would never seriously consider or contemplate suicide; speaking about a problem may make things worse and talking about suicide may encourage it. Jeffery & Warm (2002) found that nurses with psychosocial training had a greater level of understanding of self-harm but were less knowledgeable about the behaviour than those who engaged in it. House (1998) found that health professionals often perceive people who self-harm as having a poor prognosis, particularly if they have a history of engaging in this behaviour, which has implications for the implementation of recommended guidelines.

Anderson et al. (1997) stated that there is the perception that the nurse's role is to attend to the 'deserving sick' rather those who bring 'sickness' upon the self. Feelings of frustration are borne out of an inability to 'cure' the patient (Boyes, 1994). Anderson et al. (2003) described the difficulty of not being able to treat suicidal behaviour as an illness, which is an instrumental goal of medical care. As a result, medical needs of another patient can be put before those young people not requiring specific medical treatment. Medical staff saw their role as a preserver of life and suicidal behaviour was seen as contradictory to that objective. Professionals can be left feeling confused and uncertain about how to offer help as a result (Rayner et al., 2005). Malone (1996) found that Accident and Emergency staff often think that they are doing little to help patients who present after self-harm. Kelly and May (1982) state that 'good patients' confirm a nurse's role and 'bad patients' challenge their professional role. Self-harm behaviour can go against a nurse's value system (Slaven & Kisely, 2002).

It might be expected that mental health professionals show greater empathy towards people who self-harm but research does not support this assumption (Anderson, 1997). Rayner et al. (2005) explained that there are many negative beliefs held about people who self-harm, many of which are known to the person who self-harms. Young (1999) describes how behaviour and subsequent rejection from others can lead to schema maintenance of negative early core beliefs. Hence the response of nurses has the potential to be damaging as well as therapeutic. Rayner & Warner (2003) highlight that knowledge and insight can help people to remain unbiased when caring for those who self-harm. A number of nurses and doctors talked about hospital admission providing reward and reinforcing the self-harming behaviour (Slaven & Kissely, 2002). It is recommended that people working with those who self-harm receive education, supervision and training (Deiter and Pearlman, 1998)

Singh et al. (1998) explored attitudes of medical students towards psychiatry and mental illness. They concluded that a change in attitude is based on patient contact, knowledge acquisition and an awareness of positive outcomes that can result from psychiatric intervention. Medical students reported developing positive rewarding relationships through increased patient contact. Perhaps surprisingly, students became more medically orientated after a psychiatric placement despite psychiatrists attempts to emphasise a psychosocial understanding of illness. They also found that the more rigid the attitude, the less resistant it was to change. Some medical staff have reported feeling angry, disgusted, helpless and frustrated when caring for patients who self-harm. They may perceive the patient to be sabotaging their efforts to heal them (Barstow, 1995). Some report that they feel as if they are 'walking on eggshells' for fear of how their patient will respond if they say 'no' to them (Gabbard & Wilkinson, 2000). Many nurses reported a lack of confidence, which led them to feel uncomfortable dealing with people who self-harm and engaging in subsequent avoidance behaviour (Slaven & Kissely, 2002). A difficult balancing act can then result for the nurse trying to manage her time and meet the needs of her patients whilst maintaining professional boundaries, particularly if she

prides herself on having an 'individualised, flexible approach to nursing' (Cleary, 2003). Ethical and professional dilemmas are also common when dealing with someone who self-harms (Fieldman, 1988).

Rayner et al. (2005) explains the advantages of drawing from the psychodynamic and cognitive behavioural literature to gain a theoretical understanding of the experiences of both the person who self-harms and their carer. An individual's personal experience of intrapsychic conflict can lead to feelings of angst. Psychological defence mechanisms are mostly unconscious processes that aim to alleviate this anxiety, a concept which Anna Freud developed after the ideas of her father (Freud, 1936). For example, a commonly used defence mechanism is repression, where distressing feelings are blocked out of consciousness (Stevens, 2004). However, defence mechanisms can also give rise to negative emotions that can be difficult for an individual to cope with, such as: guilt; 'rescue phantasies'; rage; hatred; helplessness; worthlessness; failing to maintain professional boundaries; anxiety and fear (Gabbard & Wilkinson, 2000).

Splitting is a defence mechanism that involves perceiving someone in a polarized form, such as all good or all bad (Gabbard & Wilkinson, 2000). This can serve to reduce a person's anxiety but often results in confused reactions from nurses. Patients who self-harm may label a nurse in this way and this can then be mirrored back by the nurse who perceives the patient as all good or all bad. Splitting can occur when a patient chooses a nurse on the ward to establish a positive relationship with, thereby providing the nurse with a sense of being special. The idealized nurse is naturally flattered by this sense of acceptance but will inevitably be rejected by the patient when she betrays this perceived image by, for example, not being available all of the time. The patient then feels rejected and subsequently rejects the nurse, leaving her feeling demeaned and feeling like a failure.

Another defence mechanism is projective identification. This occurs when a nurse internalises feelings that are projected from the patient and experiences them as her own, thus blurring ownership of the feelings (Ogden, 1982). A nurse may feel like a failure after a patient that she has established a relationship with continues to self-harm. Negative feelings can then lead the nurse to question her abilities. As nurses' and patients' emotions are rarely recognised or discussed, there is a risk that they will not be processed effectively. The nurse may withdraw as a means of dealing with these feelings but thereby reinforce negative beliefs in the patient that they are, for example, unlovable. Supervision can help articulate these emotions and understand these processes at work; thereby avoiding the re-enactment of established patterns of behaviour (Rayner et al., 2005).

Racker (1957) describes concordant and complementary projective identification. Concordant projective identification occurs when the nurse and the patient experience aspects of the same emotion. For example, a patient may feel powerless when admitted on a ward and deprived of their only coping strategy while the nurse may similarly feel powerless to know how to care for this patient. Complementary projective identification involves the nurse experiencing emotions that complement the patient's emotions, as when a nurse behaves in a punitive way towards a patient who believes they should be punished. Sadly the literature provides examples of staff behaving in a punitive manner towards adult patients who self-harm. These include: negative comments being made to the person; painful restraints being used; suturing without anaesthesia; rough handling of the injured part and withholding pain medication (Barstow, 1995). Research has shown that medical staff may punish patients by making them wait, express feelings of frustration, anger, fear, helplessness and act disrespectfully towards these patients (Childs et al., 1994; Johnstone, 1997).

Nurses can experience guilt from not being able to provide a 'cure'. A nurse can also feel guilty because of negative feelings they have towards someone who self-harms, which

they perceive as unprofessional and can lead to the nurse avoiding or becoming over-involved with the patient (O'Kelly, 1998). Staff may also perceive patients as helpless and treat them accordingly. The person who self-harms is likely to feel helpless also. Nurses may feel the need to 'do' something for the patient, which can lead to boundaries being blurred and the patient feeling disempowered (Rayner et al., 2005).

A nurse may feel anger towards her patient but it is often not considered acceptable to have strong negative emotions towards a client, hence the nurse may be left to try and deal with these confusing feelings alone in the absence of supervision. The angry feelings may also be the result of projective identification (Gabbard & Wilkinson, 2000). As well as feelings of anger, it is not unusual for a nurse to feel incompetent, disliked and worthless in their professional role when they feel helpless. There can be a sense that none of their work is good enough. As the patient is also likely to feel helpless, it may be that concordant projective identification is occurring (Racker, 1957).

These emotions may be unpleasant but if the responses experienced are reflected on, they can be a useful tool in gaining insight into the inner world of a patient and constructively dealing with nurses' negative emotions. If these feelings are verbalised through supervision, a nurse's response has the potential to increase empathy and understanding (Rayner et al., 2005).

Negative feelings may not be overtly expressed, however, the nurse's demeanour and behaviour may be interpreted by the patient as rejecting. This in turn could lead to further self-harm (Connors, 2000; Hemmings, 1999). If a person feels rejected by a healthcare worker, it may reinforce their sense of lack of worth. Pembroke (1996) described how the manner in which a nurse reacted towards her influenced her self-perception and had, at times, actually provoked incidents of self-harm. Winship (1995) highlights the benefit of recognising defence mechanisms in nurses as a means of improving patient care. Thomson (1990) added that it provides a source of knowledge

and professional growth. Education, support and clinical supervision are needed to facilitate this process. It is the role of the supervisor to identify and challenge nurses negative self beliefs to allow a sense of greater awareness (Rayner et al., 2005).

Many young people who self-harm described themselves using negative words, such as bad, evil, disgusting and worthless. They frequently blamed themselves for previous negative experiences having happened in their life, like abuse (Spandler, 1996). Perceived negative responses can remind a patient of a previous abusive or negative relationship and confirm their lack of worth, which can then precipitate further self-harm. This has implications for their willingness to seek future help and may be viewed as another trauma that the individual has to overcome (Hemmings, 1999). Alexander & Clare (2004) warn professionals of the potential danger of contributing to the maintenance or escalation of self-cutting if attitudes reflect the negative social factors associated with the onset of the behaviour. A lack of formal training in self-harm is more likely to negatively impact on patient care, which in turn leads to patient dissatisfaction and a future avoidance of health services. This impacts on people seeking help if they feel suicidal and in turn impacts on mortality rates (Crawford & Wessely, 1998; Ryan et al., 1998).

People who self-harm in psychiatric settings can be seen as 'manipulative' or 'attention seeking' (Clarke & Whittaker, 1998). Labelling people who self-harm can be a defence mechanism, deflecting the issue away from the individual on to someone else. Hence the nurse does not need to examine her own attitudes, beliefs or knowledge if she sees the problem lying within the patient. Aldridge (1990) described how medical staff can adopt and use language to conceptualise patient's behaviour that may not be reflective of the patient's experience. This can then prove to act as a barrier for the nurse to gain understanding and learning about their fears and experiences (Hemmings, 1999). Anderson et al. (2003) found that staff were unable to relate their own younger life experience with that of the young person who self-harms. This acted as a barrier in being

able to communicate with them.

Establishing a trusting relationship with a young person who self-harms is an important aspect of patient care and helps to facilitate the assessment process (Machoian, 2001). Assurances of confidentiality and a non-judgemental approach towards the young person are also considered crucial (Bravender, 2002). Derouin & Bravender (2004) state that a nurse based in the community can model effective ways of communicating to a young person and offer support to parents. They also state that by identifying the underlying problem in a young person through a thorough assessment process, intervention strategies can be put in place. This can in turn have implications for challenging the contagion effect among peer groups.

Nurses are likely to have various types of beliefs, levels of understanding and attitudes towards young people who self-harm. These factors are likely to impact on the relationship that is established with the young person, which may then inhibit communication (Anderson et al., 2003). Having the opportunity to speak to a caring other may prove a relief for the young person (Burgess et al., 1998). In Burgess et al.'s (1998) study they found that almost three quarters of young people who had taken an overdose benefited from having someone to discuss their problems with. Hence having an opportunity to talk with a caring other may be a lifeline. A study examining attitudes of clinical staff towards people who self-harm revealed that 75% found it a difficult to manage problem and 65% asserted that it would be difficult to build a relationship with the patient (Huband & Tantam, 2000).

Barstow (1995) explains that a therapeutic relationship cannot be formed if the patient feels condemned and mistrustful. It is difficult to get the balance right as positive reinforcement can also occur when the patient gains care and nurturance after they have engaged in this behaviour, which can also lead to repetition in an attempt to re-establish this contact. A nurse can help a patient recognise that unpleasant feelings do not have to

always lead to self-harm. It is also important that marks indicative of possible self-harm are addressed. However, if the patient claims not to remember how they got the marks, it should be borne in mind that they may have disassociated and are not being intentionally uncooperative. Disassociation occurs when specific thoughts, emotions, sensations or memories, commonly emotionally laden are separated from mental awareness (National Inquiry, 2006).

In summary, nurses working with people who self-harm can experience a number of powerful feelings such as anxiety, anger, guilt, frustration and helplessness. These feelings can undermine a nurse's sense of competency and lead her to question her ability to remain professional in her role. A lack of understanding, knowledge and negative attitudes can combine to negatively impact on patient care. This can be reflected in the manner in which the nurse engages with the patient in both the physical care offered and the quality of this relationship.

1.6 Background to Research Setting

Child and Adolescent Mental Health Services (CAMHS) in the Highlands is made up of a Department of Child and Family Psychiatry (DCFP), a Clinical Psychology Service for Children and Young People and a Primary Mental Health Worker Service. The Clinical Psychology Service and DCFP work independently of one another.

DCFP provides outpatient care from Monday to Friday, 9am to 5pm. In keeping with Child Health Support Group (CHSG, 2004) guidelines, DCFP offer an assessment service for young people who self-harm. The Highlands and Islands region have no specialist adolescent units. Two beds have been allocated in the paediatric ward in Raigmore Hospital, Inverness, for young people with mental health problems requiring care. This was arranged to allow patient management close to home and to allow more extensive assessment of patients who live in remote areas of this Health Board. Patients can be admitted for prolonged periods because of the geographic spread of the area and

the lack of community based resources.

The Royal College of Psychiatry (1998) guidelines stipulate that all young people who are brought into hospital after an episode of self-harm are admitted. The paediatric ward in Raigmore Hospital has thirty-two beds and cares for children and young people from infancy to sixteen years. Psychiatric settings are able to consider environmental safety issues that are more difficult to control in a general paediatric ward. For example, there are a number of play materials like scissors and pens that are available as potential implements to self-harm. TV cables and suction and oxygen tubing could also be used as ligatures. The entrance of the ward is locked from the outside and controlled by an intercom and door release system. However, both doors can be opened from the inside. The staff on the paediatric ward have no holding power if a young person tries to leave the ward, instead they contact the police when a young person absconds.

There is no short stay bed available in Accident and Emergency for a young person who has self-harmed. If, for example, they need to be administered treatment after an overdose, they need to be admitted first to the paediatric ward. A risk assessment is undertaken by paediatric staff and one of two observation levels is deemed appropriate. One-to-one observation occurs when a nurse is with a patient at all times. This level is commonly used in light of the environmental risks mentioned above that are difficult to control. The young person is likely to find this degree of contact intrusive. Alternatively, the nurse may decide general paediatric observation is sufficient and need only have contact with this patient about every half hour as she tends to her other patients.

1.7 The Current Study

The majority of the literature findings outlined above relate to nurses and doctors experiences of caring for adults for self-harm or young people being cared for in a psychiatric setting. However, Anderson et al. (2003) explored attitudes of paediatric staff as part of their sample towards young people with suicidal behaviour. Participants

reported feeling fearful, frustrated and dissatisfied at the lack of time and resources available to them. They talked about the difficulty of mixing this patient group in with medically ill children. Keeping children safe was their main priority, which took precedence over using counselling skills of talking and listening to the young person.

The present study seeks to build on the findings of this valuable research study by exploring paediatric nurses experience of caring for young people who self-harm in the Highlands. Previous research identifies that looking after someone who self-harms can be an emotive and challenging role. This study aims to capture what it is like for nurses with limited mental health training to care for patients who contravene not only societal norms but norms that underlie nursing care. This is considered in context of an evolving nursing model of care which values a holistic approach. In line with the NICE (2004) guidelines, experiences of young people who had been admitted to a children's ward as a result of self-harm was sought. The young person's narrative is intended to provide a perspective on this subject matter that can be explored in the nurses' interviews. It is hoped that aspects of these experiences can be considered in unison to provide a rich, informative account of nurses' interactions with young people who self-harm.

METHODOLOGY

2.1 Design

The literature review outlined in the Introduction chapter highlights a dearth of research that explores the subjective perspectives of healthcare professionals' experiences of caring for young people who self-harm. The aim of the present study is to examine the experiences of paediatric nurses on a general medical unit caring for young people who self-harm. The rationale was to explore their understanding, awareness, attitudes and beliefs towards this patient group.

There is also a lack of research exploring the experiences of young people who self-harm. In addition, research which compares the perceptions of young people who self-harm with healthcare professionals is scarce. It was intended that a small number of young people who had been admitted to a children's ward be included in the study to offer a further dimension to the nurses experience, as well as highlighting factors that might influence this interaction. Given the sensitive nature of the topic and the lack of current knowledge in this area, it was thought appropriate to utilise qualitative research methods. Qualitative methods are considered preferable to quantitative approaches when exploring areas where there is little pre-existing knowledge (Bowling, 2004).

Different qualitative research approaches vary in their methods of data collection and analysis. However there are certain commonalties that are evident in most approaches: the individual is considered best placed to explain their experience in their own words instead of the researcher imposing a framework; the researcher immerses themselves in the setting under study, which leads to the development of 'thick description' from the data and the context (Geertz, 1973); emerging data forms the basis for theorising; the research relationship is open, honest and friendly and data collection and data analysis interact (Holloway & Wheeler, 1996).

A number of methodologies were considered. Hansen (2006) explains that ethnographic research aims to elicit a detailed understanding of a culture, which is frequently undertaken over a long period of time and also referred to as fieldwork. Lambert & McKevitt (2002:210) highlight the benefits of this approach when studying a health setting as it enables the researcher to identify difference between 'what people say, think and do', as well as avoiding generalisations. This method was considered impractical, given the time constraints of the study, and inappropriate, as participants may have perceived the researchers presence as threatening.

Phenomenology explores the meaning of individuals' lived experiences through in-depth interviews and diary entries (Hansen, 2006). This approach is popular in psychology and nursing literature, particularly in studies exploring the impact of illness and the relationship between a person's sense of self, their identity and physicality (Nettleton, 1995).

Grounded theory is a methodology that emphasises 'the perspectives and the voices of people [being studied]' (Strauss & Corbin, 1994:160). It is distinct from many other qualitative methods with its comprehensive methodology, which provides a clear 'how to do' framework that is outlined in a number of key texts (Hansen, 2006). The goal of this approach moves beyond description or simple interpretation to the generation of theory (Walker et al., 2006). For these reasons, grounded theory was the preferred methodology for this study.

2.2 Grounded Theory

Grounded theory was developed by Glaser & Strauss (1967) as an inductive method of qualitative research that would allow theory to emerge from the data through an analytical process. Discontent developed between the two researchers over their different perspectives regarding the data analysis process and the issue of verification (Walker & Myrick, 2006). Strauss & Corbin (1990) reformulated the classic theory taking these

issues into account. However, both versions still follow the same research process: gather data, code, compare, categorize, theoretically sample, develop a core category, and generate a theory (Walker & Myrick, 2006).

The main aspects of grounded theory involve asking various types of questions during analysis, utilising a constant comparative approach and using theoretical sampling (Glaser & Strauss, 1967; Glaser, 1978; Strauss & Corbin, 1998). Glaser (1992) warns that questions such as, 'What is going on here?' and, 'What is the relationship between one concept and another?' can lead to the forcing of the data into preconceived categories. However, Strauss & Corbin (1998) view the use of questions as essential and Charmaz (2000) argues that this approach offers clear guidance to the novice researcher.

Theoretical sampling is used when participants are sought where 'the processes being studied are most likely to occur' (Denzin & Lincoln, 2000:370). When theoretical saturation has been reached no new participants are needed. The 'constant comparative method' is a process where concepts or categories emerging at one stage of analysis are continually compared with data emerging from the next. Comparisons are made until no new categories or concepts emerge; a stage termed 'theoretical saturation' (Lacey & Luff, 2001). It is a cumulative process that requires the researcher to go back and review the old data in view of the emerging data (Walker, 2006). Data is analysed as it is gathered. This process begins with basic description and moves to the ordering of concepts to a stage of theorizing (Patton, 2002).

Annells (1997b) describes how the grounded theory approach has continued to diversify since Strauss and Corbin's (1990) reformulation of the classic method. Annells (1997b) outlines four basic issues that need to be considered by the researcher before selecting an appropriate mode of investigation: the researcher's personal philosophical perspectives regarding inquiry; the intended product of the inquiry; the theoretical underpinnings and the dual crises of representation and legitimisation.

Firstly, my personal philosophical beliefs fit Strauss & Corbin (1990:59) relativist ontology. They claim that 'doing analysis is, in fact, making interpretations, clarifying this by referring to the inventive nature of scientific knowledge, rather than science capturing an imitation of a supposed reality'. This method recognises the subjective nature of inquiry. Theory is jointly constructed by the researcher and the participants instead of theory being found in the data; which is reflective of a constructivist paradigm (Annells, 1997a). Experience and knowledge is deemed an advantage and should not 'block our seeing what is significant in the data' (Strauss & Corbin, 1990:95).

Secondly, the aim of the study was to provide a theory that had practical implications. Strauss & Corbin (1990) explain that derived theory should lead to an understanding of the phenomenon with direct pragmatic application, as well as providing the possibility of developing further research from the grounded theory.

Thirdly, the following theoretical underpinnings, which relate to process, social interaction and meaning, are considered useful for the current study. Strauss & Corbin (1990:5) explained the influence of pragmatism on their method of grounded theory in the quotation 'grounded theory seeks not only to uncover relevant conditions, but also to determine how the actors respond to changing conditions and to the consequences of their actions'. This pragmatist perspective influenced the emergence of a symbolic interactionism framework in grounded theory (Schwandt, 1994). Blumer (1969) coined the term 'symbolic interactionism', a process based on three primary assumptions: People behave towards others or towards things because of the meaning that person/object holds for them; this meaning is acquired through social interaction; meanings are processed through an individual's interpretation system. The adoption of a symbolic interactionist framework in grounded theory allows the researcher to examine human behaviour and interaction patterns and is particularly useful in complex situations (Chenitz & Swanson, 1986).

Lastly, grounded theorists need to consider the crises of representation and legitimisation. That is, what method best reflects the voice of the person recounting their social world experience and how can the trustworthiness of the findings be supported. As mentioned above, Strauss & Corbin (1990) follow a subjective epistemology. The data is managed through the researcher's theoretical sensitivity. Strauss & Corbin (1990:42) describe theoretical sensitivity as 'a personal quality of the researcher. It indicates an awareness of the subtleties of meaning of data. ...[It] refers to the attribute of having insight, the ability to give meaning to data, the capacity to understand, and capability to separate the pertinent from that which isn't'. They suggest it is derived from literature as well as professional and personal experience.

Having theoretical sensitivity allows the researcher to analyse the data from a distance, while maintaining a close level of sensitivity and understanding about the process and their contribution to it (Walker et al., 2006). Strauss & Corbin's (1998:87) method provides 'Techniques for Enhancing Theoretical Sensitivity'. These tools aim to 'increase sensitivity, help the user recognise bias to some degree, and help him or her overcome analytic blocks', which are particularly useful to a researcher new to this field of inquiry.

2.3 Literature Review

A literature review was carried out using a number of keywords including: self-harm; deliberate self-harm; self-injury; self-injurious behaviour and self mutilation. Ovid, Blackwell Synergy, MEDLINE, CINAHL, EMBASE, PsycINFO and the British Nursing Index were the databases used to retrieve journal articles. The Royal College of Nursing website was also examined for relevant material. Professor Keith Hawton, prolific researcher in the area of self-harm, provided guidance on pertinent literature in this area. Nursing academic staff attached to the University of Stirling gave useful direction in the nursing literature field.

2.4 Sampling in Qualitative Research

Qualitative research utilises theoretical sampling (or purposive sampling) which aims to identify and include those participants who will provide a ‘full and sophisticated understanding of the phenomena under study’ (Rice & Ezzy, 1999:42). The goal is not the representative capture of all possible variations but ‘to include ‘outliers’ conveniently discounted in quantitative approaches’ (Barbour, 2001:1115) to gain a deeper level of understanding. The size of the sample is small and the numbers of participants vary depending on the findings generated through the analytical process.

2.5 Sample Recruitment

2.5.1 Nurses

Nurses working on a children’s ward in a regional Scottish Highlands hospital were approached for this study. The researcher visited the Children’s Ward on three different occasions, with the permission of the ward Sister, to speak with nursing staff about the intended study. Information sheets (see Appendix 1) summarising the study were provided to all those nurses who expressed an interest in this research. Potential participants were also given a brief questionnaire to obtain demographic information and to assess whether they were interested in learning about paediatric mental health (see Appendix 2), along with a stamped addressed envelope to be returned to the researcher if they decided to participate. Details captured in the questionnaire are outlined below. No time limit was stipulated for the return of completed forms but it was explained that it was the researcher’s intention to carry out interviews over the proceeding three months. Additional information sheets with relevant forms were placed in the ward staff room. On receipt of the completed forms, the duty rota was checked by the researcher and the identified nurse contacted during their shift on the ward to arrange a convenient time to meet. Consent forms were completed prior to the interview.

2.5.2 Young People

Young people were sought for this study indirectly through their mental health professional; who acted as a 'gatekeeper'. Gatekeepers are people who are in a role that can exert a high level of influence in accessing a sample (Hansen, 2006). This was due to ethical considerations, which are discussed later in this section. A research proposal was presented to the local Department of Child and Family Psychiatry and the Clinical Psychology Service for Children and Young People. A summary of the research protocol (see Appendix 3) was also sent to the Primary Mental Health Workers who are based in the community. An information sheet, participant consent form, parent/guardian consent form and a letter addressed to the parent(s)/guardian(s) (see Appendix 4) of potential participants under the age of sixteen were disseminated to these professionals. Team members agreed to present the details of the study to any young person on their caseload who they considered appropriate to participate. That is, the young person was considered to be coping well with the present demands in their life and met the study's inclusion criteria. It was intended that on receipt of completed consent forms the young person would be contacted to arrange a suitable time and place to meet.

Two females were identified but one potential participant below the age of consent was unwilling to ask the permission of her father and another young person was no longer under the care of a health worker, which was a stipulation agreed with the ethics committee. All gatekeepers were contacted individually by telephone to remind them about the study and a further e-mail was sent before interviews ceased. Despite the researcher's best efforts, no young people were successfully recruited.

2.6 Characteristics of the Sample

2.6.1 Nurses

Eight female nurses participated in the study (see Appendix 5).

Psychiatric experience: The length of time varied from five months to thirty-six years. Five nurses completed a psychiatric secondment during their training which ranged from six weeks to three months. One participant was also a qualified psychiatric nurse. Three nurses had no experience of a psychiatric secondment.

Three nurses reported never having attended paediatric mental health courses. Three nurse completed a one day suicide risk assessment course. One participant had attended a five day adolescent mental health course and another nurse had completed two university modules in child and adolescent mental health. All eight participants indicated they would be interested in learning more about paediatric mental health.

2.7 Inclusion Criteria

Participants needed to be qualified paediatric nurses working on the Children's Ward and willing to be interviewed.

2.8 Exclusion Criterion

Participants who would not grant their permission for their interview to be audio-recorded were not included. Morse (2001) stated that researchers are limited in their use of participant quotations if the interview is not recorded, which therefore influences the researcher's ability to truly ground the study. No participant in the present study was unwilling for their interview to be taped.

2.9 Ethical Considerations

The study was granted ethical approval by the Highlands' Local Research Ethics Committee prior to starting the study.

The provision of information sheets allowed potential participants to consider the details of the study and give informed consent if interested in taking part. All potential participants were informed that they could withdraw at any stage of the research process

without explanation.

It was made known to potential participants that confidentiality would be maintained except in the event that there was concern for the participant's welfare or that of someone known to them. The relevant health, social and/or legal agencies would be contacted if deemed necessary. This was not necessary. All personal details and interview data were kept in a secure locked cabinet that only the researcher has access to, in the researcher's place of work; a child and adolescent psychology department.

Potential participants (and parent(s)/guardian(s) where appropriate) were provided with the contact details of the researcher and her supervisor. They were invited to telephone either person if they had any concerns or queries regarding the research. Potential participants were given further copies of these contact details before the interview took place and encouraged to get in contact if they experienced any upsetting feelings after the interview had taken place. This did not occur.

Only those young people in the care of a mental health worker were considered for this study. This allowed the gatekeeper to discuss the advantages and disadvantages of participating in the study with the young person. It also ensured the provision of care in the event that the young person experienced any distressing emotions as a result of participating in the study.

Informed consent was needed from both the young person and their parent/guardian if the young person was under the age of sixteen years. The parent(s)/guardian(s) of a participant was/were informed that in no way would a decision to participate or not to participate in this study influence the mental health support their child presently received or their future care.

2.10 Pilot Interviews

Two interviews were carried out with nurses drawn from the nursing sample in the study. The interviews were transcribed and analysed in an effort to improve interviewing technique and receive constructive feedback from a more experienced qualitative researcher.

The researcher is a Trainee Clinical Psychologist and is used to carrying out clinical interviews. However, the role of a clinician is different to that demanded of a researcher in terms of the questioning approach that is utilised. The process of carrying out two pilot interviews allowed me to recognise that I was too passive in my approach initially and too directive on the latter occasion. I gained confidence and became more comfortable with this approach as a result. Analysing the transcribed data also allowed opportunity to practice the analytical method and gave an awareness of the time involved in the process.

2.11 Interviews

It was important to make all participants feel as relaxed as possible. Charmaz (2000) recommends the use of a natural setting when interviewing participants in order to encourage dialogue. Five interviews were held during the nurse's working hours in a private room in the Maggie's Cancer Care Centre, which is located on the grounds of the hospital. The novel architecture of the centre provided a useful topic of conversation and lent itself well to making the interview feel as informal as possible. The centre's layout is modelled on that of a home and allowed both interviewer and interviewee to enjoy a cup of tea or coffee with biscuits as they talked. The ten minutes walk from the ward to the centre provided a good opportunity to begin rapport building after the participant had been met by the researcher on the ward. The nurse could be paged back to the ward if needed. This did not happen. The other three interviews were held in a quiet private room on the ward, as it was more convenient for the participants at that time.

A separate consent form seeking permission to audiotape the interview was introduced immediately prior to the interview and anonymity guaranteed (see Appendix 6). The consent form also offered a place for participants to indicate whether they wished to be sent a summary of the research findings. All interviews were transcribed verbatim.

Participants were advised that they were free to stop the interview at any point. They were also reminded about the contact details of the researcher and her supervisor in the event that they felt upset after the interview. For young people who participated, it was arranged that the mental health worker would be contacted by the researcher if the young person felt they needed to speak with them following the interview. However, as no young people were interviewed this was not necessary.

Each interview opened with a question that inquired about the course of the participant's nursing career to date. It was expected that this might aid a participant to relax. The format of the interview was generally unstructured to allow for open fresh dialogue. Glaser & Strauss (1967) point out that often the researcher just initially listens to the participant's narrative and as the study progresses the interviews become guided by the emerging theory. An interview guide (see Appendix 7) consisting of a number of areas of interest was compiled. Schreiber (2001) supports the use of an interview guide as it prevents the researcher from imposing their own structure on the data and allows the interviewer to quickly assess whether all areas have been covered before the interview is completed. The interview guide was led by the emerging data. For instance, when the theme of supervision was consistently brought up in the initial interviews, more direct questioning was introduced in later interviews when participants spoke about this common theme.

The interviews ranged from thirty minutes to sixty-five minutes with an approximate average time of fifty minutes.

At the end of each interview when the recording equipment had been switched off participants were engaged in general chat before finishing the session.

The researcher wrote down her impressions after each interview to compare this information with thoughts generated during the analytical process.

Nursing participants were asked for their permission to be approached for a further interview. This allowed additional time to revisit specific themes if required. This was not considered necessary as there was a natural development of themes in subsequent interviews.

2.12 Data Analysis

The transcribed interviews were analysed initially through a process of open coding (see figure 1). The data was broken down into meaningful segments of words, phrases and sentences and then labelled with descriptive words. Data which had been coded was placed into relevant categories. Glaser & Strauss (1967:36) explain that ‘a category stands by itself as a conceptual element of the theory. A property, in turn, is a conceptual element of a category’. Using the constant comparative method, new data was compared with old. This led to the creation of more abstract categories and a revision of previously generated categories. This level of coding allowed the researcher to immerse herself in the data and aided in the development of themes.

Interview transcript	Open coding
We used to take them out for cigarettes so we'd stand at the door	Privacy
and she used to sort of you'd just say oh was that you boyfriend	Talking
just ask little questions and then it'd all sort of come out	Disclosure
and you'd get sort of a bigger picture about what's happening at home	Insight

but yeah I kind of find if you treat them like they're somebody you	Pt Care
know treat them more friendly as opposed to a patient that has done wrong	Judging
you shouldn't be taking that, you shouldn't be doing this	Ordering
but I know a lot of people on the ward just hate having them on the ward.	Hate

Figure 1: Example of line by line open coding

Axial coding is the process whereby the researcher begins to make tentative links between the open codes. The categories at the first level are largely descriptive and at the second level become more analytic. In the above example, some of the codes were categorised as 'Being in the picture' (principal category), which was subsumed under the four main categories as well as the core category. Open and axial coding occur together as part of the constant comparative method where the researcher moves back and forth between different levels of coded data.

The data was reanalysed and fewer more inclusive categories (main categories) were generated. This continued until no new categories were generated and all data fitted the existing categories. An overarching core category developed which was supported by the main categories. Core and main categories are made up of principal categories, which are reflective of subcategories and themes. Some data may be coded under different conceptual headings, which is what gives rise to main and principal categories. The main categories can be related to each other but are considered independent in that they describe an important aspect of the core category. The principal categories are lower level than the main categories as they reflect some or all of the salient themes of the main categories. Hence all themes evolved into categories and these categories were reflective of the narratives.

Memo writing allows the researcher to keep a record of the analytic process (Strauss & Corbin, 1998). Memos were written to keep track of ideas and thoughts about the data and how the analysis progressed (see figure 2).

Doing something – 19/04/06

This memo is about the category ‘control’. The nurse seeks to gain it through following protocol. However, this has implications for the young person. N1 describes ‘having to do something’ when the young person who was resuscitated on the ward after attempting to hang herself refuses to speak to her. The team involved sat down with her together ‘to get her to understand’. The young person cries and then apologises....contd.

Adopting this approach may mirror relationships in the young person’s life where power differentials exist. If, for example, the young person had been abused, this dynamic between her and the professionals may be perceived as threatening. Although the young person’s experience is not explicitly described, it is thought necessary to create a separate category that encompasses any possible feelings experienced. A name for this category could be young person’s experience, feelings or emotions on the ward.

Figure 2: Example of a Memo

Analytical Process of Present Study		
		Memos
Stage 1	Audio recordings of interviews transcribed.	
Stage 2	Listen to interview recording and check for consistency against transcript.	
Stage 3	Data is fractured through line-by-line analysis in process of open coding. Concepts are written in the margin.	

Stage 4	Open coding also undertaken using Nvivo 2.0 software package. This allowed the researcher further immersion in the data and provided a more proficient method to organise and retrieve codes.	
Stage 5	After coding interviews one, two and three, concepts compared and grouped into major categories. Features (properties) and dimensions of these categories are identified.	
Stage 6	Subsequent interviews guided by categories previously identified, as well as remaining open to what participants had to say.	
Stage 7	Open coding continues with interviews four and five. Axial coding identifies connections between categories in a process that begins to put the data back together. Principal categories identified.	
Stage 8	Selective coding identifies core category which links to the main categories.	
Stage 9	Interviews six and seven focus on core category and its relationship to the main and principal categories.	
Stage 10	Saturation of categories reached after the sixth interview. Two further interviews were carried out to ensure saturation.	

Stage 11	Three participants were presented results so findings could be checked.	

Table 1: An overview of the analytical process of the present study.

2.13 Data Management

The digitally recorded interviews were downloaded onto a computer, saved, anonymised and deleted once transcribed.

The software package NVIVO 2.0 (QSR, 1999-2002) was used to analyse and organise the data.

2.14 Reflexivity

Sword (1999) highlighted the fact that researchers undertaking qualitative work frequently fail to recognise or report their role in the construction of reality. Pope et al. (2000) described reflexivity as a 'sensitivity to the ways in which the researcher and the research process have shaped the data collected, including the role of prior assumptions and experience, which can influence even the most avowedly inductive enquiries'. They also explain that a researcher's openness about personal and intellectual biases as well as their personal characteristics needs to be made known in order to enhance the credibility of the findings.

The researcher has a particular interest in health psychology and child and adolescent mental health. Over the past number of years, a biopsychosocial model of care has become increasingly more popular in nursing than the disease orientated focus of the biological model (Chan, 1996). However, I am aware of incidences where lack of resources has led to a greater emphasis being placed on a medical model of care that fails to meet the holistic needs of patients in hospital. I find this frustrating and I recognise

that I am motivated to seek solutions where I see disparity and my optimism allows me to believe that things can always evolve into something more positive.

When I was nine years of age, I acquired what was thought to be a sports knee injury that led to numerous medical investigations. The cause of the problem was not identified until a number of years later and the intermittent discomfort that I experienced up until this time was not, in my opinion, recognised as being valid by others until a label was assigned to describe it. I welcomed the diagnosis because I perceived it to alter the view others had of me. As a result I can empathise with people who are judged as wasting professionals' time.

In my experience as a trainee clinical psychologist, I have worked with adults who self-harm that reported both positive and negative experiences of working with health professionals.

However, I also have an insight into the nursing profession as my two sisters are paediatric nurses and I recognise from their work the practical issues of care and the stresses involved for staff. One of my sisters works on the ward where I drew my sample from. As I was known to some of the staff through my sister, it may have led only those nurses sympathetic to young people who self-harm to offer to participate. Those who did take part may also have felt conscious of offering socially desirable responses. Hence, the interview was unstructured, took place in a relaxed environment and time that allowed good rapport building to address these issues.

I am also known to some members of staff through my clinical work on the Children's Ward. As participants were in their uniform at the time of the interview, it was felt important to dress smart casual and allow the participant to choose which seat to sit on during the interview to go some way in addressing any power differential that may have existed.

2.15 Ensuring Rigour

All research needs to adopt an approach that is both reliable and valid. However, Stauss & Corbin (1990) believe that the usual principles applied to evaluating quantitative work needs some redefinition when considering work that is not from a positivist paradigm. Lacey & Luff (2001) outline a number of considerations that are needed to demonstrate the reliability of analysis. These include: a description of the research approach and analysis procedure; justification of why this approach is appropriate; use of an audit trail and referring to external evidence to assess the findings drawn. Janesick (2000) asserts that there is no exact way of interpreting an experience but the credibility of interpretations may be made more credible by the use of audit trails or member checks.

An audit trail is a technique for making the researcher's interpretations of the data transparent; where records are kept of the decision making process throughout the research. According to Lincoln & Guba (1985) it allows confirmability of the findings reported.

Member checking offers respondent validation of results and enhances the credibility of the findings (Strauss & Corbin, 1998). Two participants agreed to offer their perspective on the findings of the study. A verbal summary and a diagram depicting the categories and their relationship to the core category were presented. They identified with the results and offered useful feedback, which is outlined in chapter four.

A qualitative study cannot claim to be valid in terms of representing the 'truth' if the researcher is working from a paradigm that believes that multiple 'truths' exist. Validity is judged then by the degree to which an interpretation seems to fairly and accurately represent the data gathered (Lacey & Luff, 2001). To achieve this, representative quotations were used to allow the reader to see how interpretations were related to the data. Data was also subject to inter-rater analysis to establish comparisons of

interpretations made by the researcher with an Assistant Psychologist (LW). The second rater blind coded interview transcriptions that had previously been analysed by the researcher. Discussions of both analysts findings were compared and discussed.

Acknowledgement was made about the impact of the design on the results presented by making the analytical process transparent by engaging in reflexivity. Extracts from this diary are presented in this piece of work. Triangulation is also a method of demonstrating rigour. It involves gathering and analysing data from more than one source (Lacey & Luff, 2001). Interviewing both young people and nurses in the current study aimed to provide greater depth of insight. It led the researcher to consider the data from one source and evaluate it in light of another, taking in to account similarities and contradictions offered. As no young people could be recruited for this study, others sources of data reflecting young people's experiences were included (Hawton et al., 2006; National Inquiry, 2006; Spandler, 1996).

2.16 Research Diary

The use of a research diary allowed me to keep a record of the decision-making process throughout the research. Research issues were described, as well as the resolutions that were generated as a result. It was used in conjunction with the memos written about the analytical process and the reflective diary. Excerpts from the reflective diary are illustrated in the Method Critique. The research diary is used to ensure rigour by providing transparency and confirmability of findings (Lincoln & Guba, 1985). The diary allowed me to clearly trace back interpretations made to the generated data. This served to increase my confidence in the analytical process.

The research diary was initiated early in the research process. For example, it provided clarity when I questioned the appropriateness of utilising the current sample. I had a number of concerns regarding the fact that my sister works in the setting that I gathered my sample from. It raised concerns about whether nurses would feel obliged to take part,

whether the answers given would be more likely to be influenced by social desirability factors, as well as the impact of conducting this research in my sister's work setting. I discussed this issue with my sister and she raised the point that as I am not a stranger to staff on the ward they may, in fact, be more willing to speak with me than if I was just known in a professional capacity. She was encouraging and expressed the belief that it was a subject matter that staff on the ward would be interested to discuss. Despite acknowledged limitations, I decided to pursue this research sample. I also emphasised assurances of confidentiality and anonymity to ensure that participants felt confident that any information given would be respected. This was considered important in the event that a nurse may have perceived a potential risk that I might speak to my sister about the information revealed in their interviews. Interestingly, a nurse on the ward introduced me to a colleague as X's little sister. I wondered about the perception that this description may bear on my role as a researcher but on reflection decided that this may have served an advantage in being viewed as less threatening.

The research diary also helped in decision-making regarding the recruitment process. For example, the ward sister offered to provide a list of nurses which detailed the names of those she believed to like, dislike or be neutral towards offering care to young people who self-harm. I was curious to see how these names compared to the list of participants that agreed to participate. However, this offer was declined as the list would have just been representative of her perception but the fact she thought it possible to separate nurses into these three groups was telling in itself.

A sense of frustration was reflected in this research diary regarding the lack of support gained in efforts to recruit a sample of young people. The ethics committee stipulated that I rely on gatekeepers to identify young people. The lack of feedback that was experienced from gatekeepers meant that I felt uncertain and disheartened as a consequence. It struck me that these feelings were reflective of concordant projective identification with the nurses. Although I continued to feel frustrated throughout the

research process, as their inclusion would have added an additional dimension to this research, I resolved this issue by recognising the wealth of data generated from the nursing sample and the richness these narratives provided.

The research diary proved valuable in the analytical process. With regards to engaging with the data, there was a clear sense of feeling overwhelmed at times by the quantity of data that was generated from the transcripts. The constant comparative method of analysing new data with previously obtained data proved increasingly challenging as the body of data expanded. As a novice qualitative researcher, I questioned my ability to thread all the information together in a coherent and representative manner. The use of diagrams describing the codes allowed me to conceptualise emerging themes and relevant categories. These illustrations became increasingly complex with the addition of newly generated data but they also gave rise to an emerging narrative that enabled me to tell the nurse's story as well as an emerging confidence in undertaking this research process.

The diary also helped me to keep focused on the research goal. Nurses talked about young people feigning illness, which I was curious to explore given my own personal experience, but my diary entries served to keep me on track.



FINDINGS AND DISCUSSION

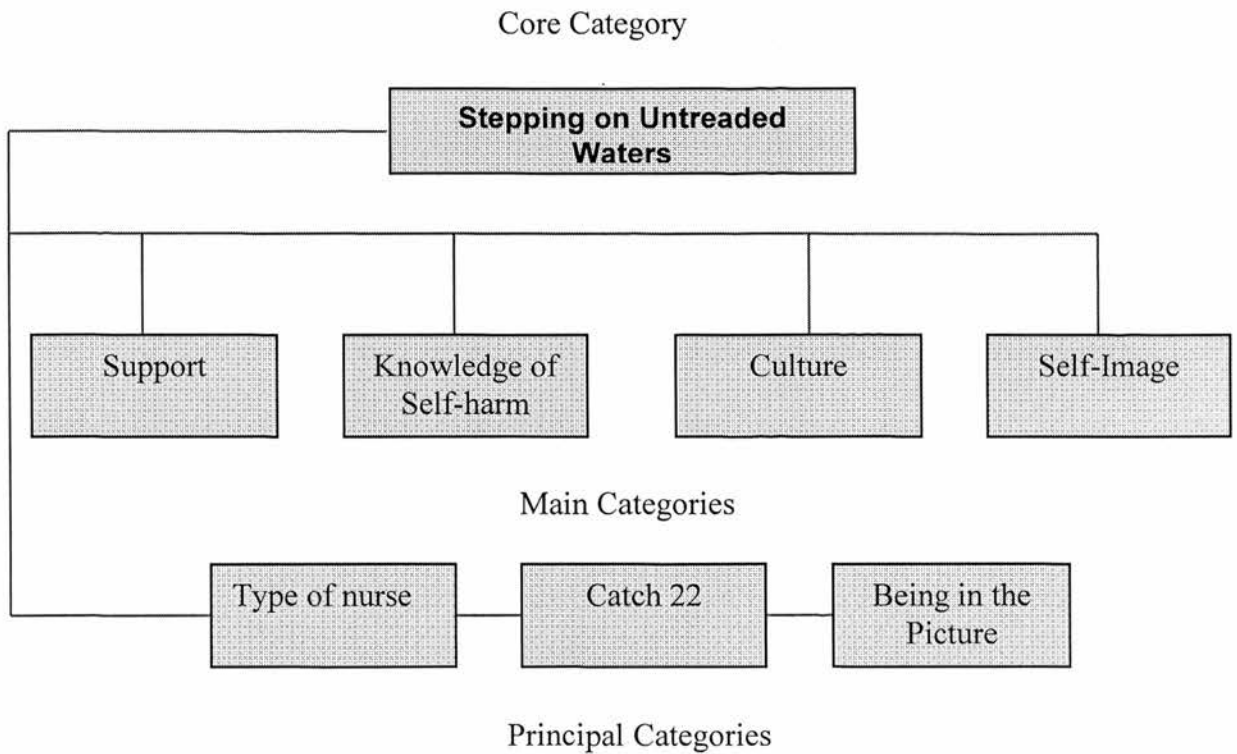


Figure: 3. Architecture of Categories

3.1 Core Category

Through a process of modifying, rejecting and developing categories, the main problem for the participants emerged as ‘Stepping on untreaded waters’ when they are involved in the care of young people who self-harm.

One participant, quoted in ‘Catch 22’, talked about ‘Stepping on untreaded waters’. This quote was used to conceptualise the careful navigation that is required when dealing with complex problems. Barker & Buchanan-Barker (2005) likened the process of researching mental illness to negotiating a path through ‘unchartered waters’, some depths of water are familiar whilst others are considered potentially treacherous. Similarly, in the present study there is a pervading sense of uncertainty amongst participants and a sense of

feeling unsafe when caring for young people who self-harm. This patient group are perceived to have problems that have led to this behaviour and it is the potential disclosure of the extent of these problems and the nurses perceived capacity to offer help that make each unique patient presentation reflective of 'Stepping on untreaded waters'.

Strauss & Corbin (1998:146) asserted that 'in an exaggerated sense the core category consists of all the products of analysis condensed into a few words that seem to explain what the research is all about'. The core category 'Stepping on untreaded waters' is central to the present study and relates to the main categories, dimensions and sub-categories. Strauss (1987) described criteria that is necessary for a category to be considered a core category, which this present study met. The core category was mentioned in the data frequently and has implications for a formal theory. A formal theory was generated as self-harm appears to be an emotionally provoking problem for healthcare professionals who need to meet the needs of a young person who requires help beyond their perceived competencies.

The core category consists of four main categories, each of which has sub-categories. The core and main categories are comprised of principal categories, which reflect further sub-categories and themes. The main categories are 'Support mechanisms', 'Knowledge of self-harm', 'Culture' and 'Self-Image'. 'Support mechanisms' reflect the use and availability of the participants' support systems. 'Knowledge of self-harm' is related to attainment and influence of information on patient care. 'Culture' represents the beliefs and behaviour that are portrayed in the ward environment. The last main category 'Self-image' relates to participant's perceptions of themselves as an effective and useful practitioner. Each category is explained in further detail in this section.

Main categories represent important themes that emerged from the data. They are broader than the principal categories which represent aspects of the main and core categories. For example, the principal category 'Catch 22' contains elements of all four

main categories and the core category. Its inclusion gives greater breadth to the nurse's experience but in isolation of other categories it does not serve to have the explanatory power of a higher level or main category.

The principle categories consist of 'Type of nurse', 'Catch 22' and 'Being in the picture'. 'Type of nurse' related to differences in nurse training and personality that impact on the role of carer. 'Catch 22' reflects the dilemma of juggling the role of safe-keeper and friend to the patient. 'Being in the picture' represents factors that influence the process of attaining information.

The most salient theme that emerged from the initial interview was the uncertainty that prevails in the absence of knowledge. This theme was generated throughout all subsequent interviews and the analysis revealed that this often leads to an isolating experience when support mechanisms are not utilised effectively. Participants generated a number of strategies that could be employed in helping to relieve this uncertainty which led to the development of a model that provides support and security which is entitled 'Stepping on safer water'.

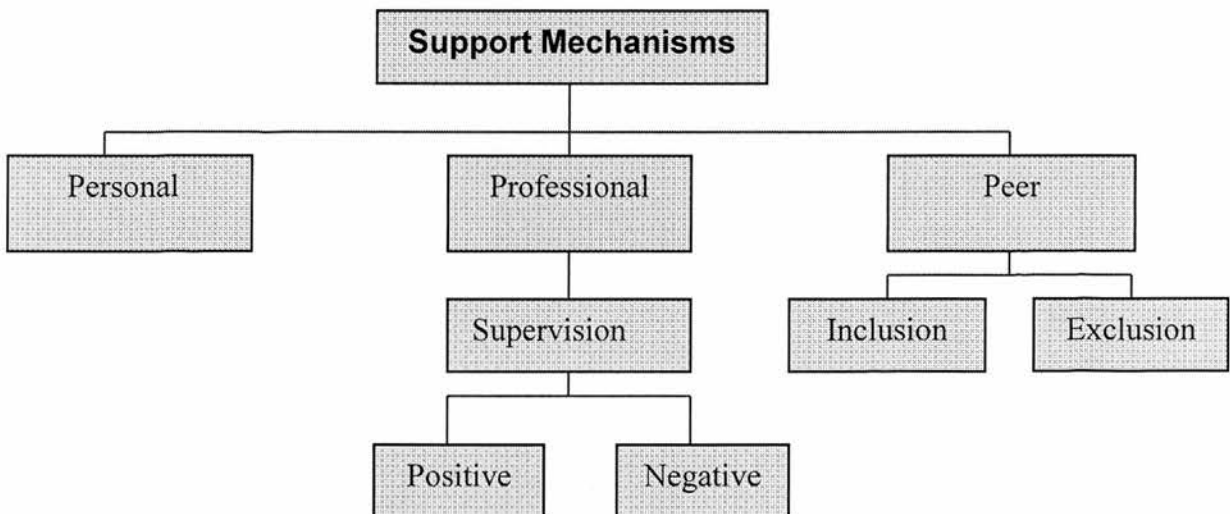


Figure: 4. Main category: Support Mechanisms.

4.1 Support Mechanisms

Participants referred to three support mechanisms that could be accessed with different levels of success. This triad includes: an individual's own personal resources; the provision of informal peer support from fellow nursing colleagues and wider systemic support mechanisms provided by multiprofessionals, such as supervision.

4.1.1 Emotions Evoked when Caring for People who Self-Harm

All participants talked about experiencing varying degrees of uncertainty when caring for young people who self-harm. Some positive emotions were evoked, such as feeling competent but primarily negative feelings were discussed. These included frustration; guilt; hate; fear; inadequacy; feeling emotionally drained and disheartened:

N6: I just think everybody worries cause we just don't know how to deal with it. It'd be like a mental health nurse coming into a medical side and thinking, 'aghhhh! What do I do with this patient whose diabetic?' It just does make you feel inadequate.

N7: ...what we did in the first place.. was that any use? Or the follow up, you know social work, did they actually help in any way? And I suppose by them coming back again, well you think no it didn't ...they're here again, ehm it's a bit disheartening really.

These findings are supported by Allen & Beasley (2001:73) who assert that 'self-harm is undeniably an emotive issue, which evokes a response and opinion arguably in all of us'. The feelings that many participants talked about in the present study are reflective of the counter-transference reactions experienced by people working with those who self-harm (Gabbard & Wilkinson, 2000). Rayner et al. (2005) explain that it is not unusual for a nurse to feel incompetent, disliked and worthless in their professional role when they feel helpless.

4.2 Support Mechanisms: Personal Support

With regards to personal support, some nurses found it easy to detach from their work but others felt that this was difficult to achieve:

N5: I'm always worried about them. And after they leave, I still worry about them, while everyone else just forgets about them. I go home after having these kids and I'd sit and think about them for long enough and go. 'oh I should have done this' or 'maybe I should've...' there's not really much I can do cause there's nobody I can go home and speak to.

It is recommended that nursing staff achieve a balance in their professional and personal lives to cope with the emotional impact of their job (Deiter & Pearlman, 1998). This can be difficult to achieve when an individual feels emotionally isolated in their professional role and has no means of processing these feelings. Rayner et al. (2005) stated that it is a supervisor's role to foster self awareness skills in a nurse by helping them to identify and challenge negative self-beliefs. However, it could be argued that these skills may not be in a nurse's repertoire and as such highlight the need for further training.

4.3 Support Mechanisms: Professional Support

Relationships with members of the multi-professional team were portrayed both positively and negatively. Team members could provide information and care that nurses felt ill equipped to offer. However, they were also the source of some frustration:

N1: If the CPNs could do their job properly why are these people coming in and in and in and in and in, again and again and again? {critical tone}

And later

N1: Yeah and especially cos they're in for a long time, I mean by the time Social Services actually get the finger out and actually put things in place for these kids.

N8: ...a lot of the problem here is social work are quite slow.....and we've babysitted a couple of kids that shouldn't have had to come into hospital.

These results corroborate the finding that self-harm evokes frustration in staff and the difficulty experienced trying to offer help (Boyes, 1994). Participants conveyed a sense of frustration at the system of care provision for young people. Anderson et al. (2003) found similar findings in their study exploring medical staff's perceptions of young people who attempt suicide.

Hardwick (1991) emphasised the need for role clarity in multidisciplinary team working. He referred to a behaviour termed 'deference', which is enacted by anxious workers uncertain of their role who overestimate the ability of other professionals to 'fix' the problem. Hardwick also referred to scapegoating as a means of blaming others whilst avoiding examining the workings of ones own profession.

4.3.1 Supervision

Some participants expressed the value of professional support mechanisms but used words like 'debriefings' and 'reflective practice' instead of supervision:

- N2:** ...we had debriefings you know where we could just discuss whatever issues we had....you know when these patients went home we would have meetings afterwards and it would be primarily for the staff that looked after the children to discuss their anxieties and how they'd felt.
- N4:** I do get cross when I see how things could be done and you can't change it...I would like more reflective practice and time for that.

Participants appeared to lack insight into the role of other MDT members. Most participants were uncertain as to the purpose of clinical supervision and many expressed feeling threatened at the prospect of it:

- N4:** When you said supervision, I originally thought that you meant either supervising a nurse that wasn't so sure or you know a young nurse supervising her doing something ehm but then I wondered if supervising a patient ehm but I tend not to use that word.
- N5:** Supervision they do in DCFP [Department of Child and Family Psychiatry] and I

got it there but they don't do it here. Yeah, yeah that was more or less what x had offered...it was reflection but she'd offered 'supervision' and I think maybe that's part of the reason why people weren't up for it cos they'd be thinking 'were not needing supervised'.

N8: Supervision for us is someone standing over your shoulder watching what you're doing which is a total different kettle of fish and makes you feel incompetent.

Gray (2001) describes the word clinical (according to the New Collins Dictionary & Thesaurus, 1995 edn.), as 'of or relating to the observation or treatment of patients directly', and supervision (according to the Concise Collins Dictionary & Thesaurus, 1995 edn.), as 'to oversee the actions or work of a person'. Aldridge (1990) described how the use of language without shared meaning can act as a barrier between professionals and patients. The data in the present study gives rise to an example of a barrier that exists between professionals because of a lack of shared meaning in regards to the purpose of supervision.

Earlier research suggests that clinical supervision can provide a useful space to explore and deal with unresolved feelings (Faugier, 1994). The process is also thought to counteract feelings of discouragement (Firth, 1986), emotional exhaustion (Willkin, 1988) and burnout (Faugier, 1993). Nicklin (1995) suggest sharing ideas and experiences regardless, of grades or specialty can lead to the development of valuable clinical skills.

Mullarkey et al. (2001) argue that multiprofessional supervision increases learning opportunities, collaboration and co-operation. It also allows for greater transparency of roles undertaken by different professionals, to encourage more effective working. However, it is recognised that multiprofessional working may be perceived as threatening and lead to the adoption of defence strategies, such as blame attribution. Butterworth & Woods (1999) believe that organisations have a responsibility to provide supervision for staff and allow them time to access it on a regular basis.

Yegdich (1999) explained that there can be a 'conceptual muddle' between the definitions and aims of clinical supervision. Some models of supervision favour a case management orientation whilst others seek to enhance skills by providing support to the practitioner. Mullarkey et al. (2001) also highlights the need to distinguish the aims of supervision depending on the level of seniority and experience people have gained. As participants conceptualised the word supervision in terms of watching a less experienced nurse perform a task, this may have increased their sense of unrest at being offered the same supervision as the more junior nursing grades than themselves. It is therefore essential to be clear about the objectives of supervision, if indeed it is helpful to use this word, and whether that is offered from nursing colleagues or from an external agency.

4.4 Support Mechanisms: Peer support

Some participants benefited from peer support, but the data illustrated that this could be influenced by membership of a clique. A distinction was also made between the levels of support gained from senior staff compared with more newly qualified members of the nursing team and the influence of different personality types working together. These aspects are explored under main category 'Type of Nurse':

- N1:** No, we didn't have any clinical supervision but ehm... we... ourselves would just sit down and chat over coffee.
- N4:** There are certain cliques among the staff as there is in any work place which I'm not a part of...there is break time but a lot of nurses just want to read a paper or something they're just not, not focused because they want a break.

Cohen et al. (2000) stated that sharing experiences helps foster a sense of belonging, which is positively related to job satisfaction (Bratt et al. 2000). An organised form of peer support can reduce emotional isolation (Bedward & Daniels, 2005) and lead to professional development (Vourinen et al. 2000). However, informal peer support can lead to closed group alliances, which only benefits those members in the group and can prove to alienate those outside the alliance (Lutzen, 1990). The findings of the present

study point to a need to utilise the positive relationships on the ward by introducing support skills training (Bedward & Daniels, 2005) to allow peer support to have a more structured format that makes it more accessible to all.

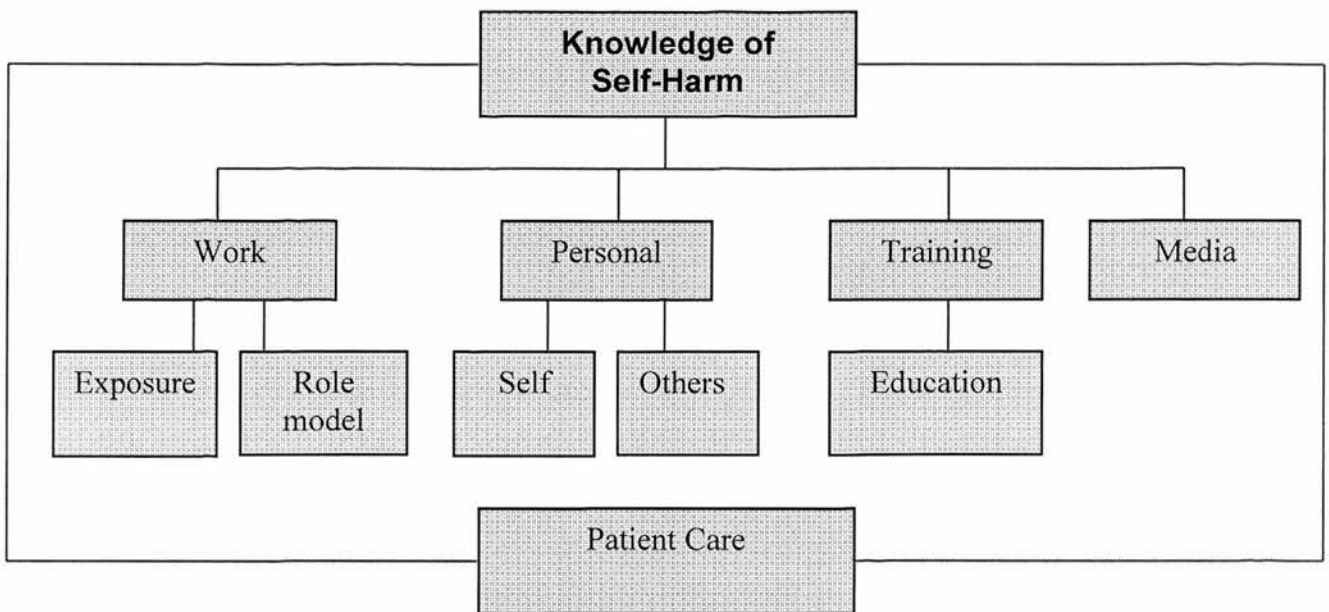


Figure: 5. Main Category: Knowledge of Self-Harm.

5.1 Knowledge of Self-Harm

All participants referred to a number of sources where knowledge of self-harm could be acquired: work experience, personal experience, training and media. However, there was a general consensus that there was a lack of formal teaching regarding mental health problems pre and post qualification for all nurses.

5.2 Work Experience: Exposure

Exposure led to a questioning of previously held beliefs and also provided motivation to complete post qualification training:

N1: I've seen them also do their thighs and that way it's more hidden....It's not to get attention. But that made me think I can't see it.. Why is he doing it? That made me think a little bit more having had no training in it... to me that was

even odder because no one can see it. Why are you doing it? Why are you bothering? {Speech quickens}

- N5:** I was one of her [young person who self-harms] key nurses so that's when I got first interested in it....that's when I decided that that was what I wanted to study cos I enjoyed it that much.... I didn't really encounter anything until I came to work here straight after my training...I always felt it was a bit scary when someone came in cause I didn't know what to do with them and you just thought if anything did happen....you'd feel terrible...that was another reason why I wanted to do training in it.

Arbon (2004) suggests that experience is gained through a process called meaning-making, where preconceived ideas and theory are modified through engaging in practical situations. Hence, experience can lead to learning if it is reflected upon (Rolfe, 1997). Khomeiran et al. (2006) explored competence development in nursing staff and found that difficult situations, which challenged nurses skills and knowledge often acted as a stimuli to learning. However, this was mainly the account of nurses early in their career. The present study found personality type and a nurse's level of interest in the area of self-harm to be more important than length of time qualified as a motivating factor to acquire further knowledge. This is discussed further in main category 'Type of nurse'.

5.2.1 Work Experience: Role Model

Participants talked about role models:

- N2:** ...when I did my training you...learnt from your role models [who] were your other staff so that's what you learnt, and if you thought this nurse was... even if they were horrible, you would be doing, thinking everything they did was right.

And later

- N2:** ...when I trained if you asked the staff nurse and she said do it that way and you go [to yourself] I don't actually agree with that but you wouldn't actually question her on it.....you'd still go ahead and do it... whereas now they're, I think they're taught to be far more ehmresponsible for their own actions to be evidence based, research based and stuff like that...they'll question you.
- N3:** ...she was one of the people I kind of thought hmmm...yeah I want to be like you.....she was really good you know, she never really said very much she just gave her [young person threatening suicide] a hug and I just thought that's really good cos I wouldn't have known what to say if it had been me on my own

in that situation.

Social learning theory proposes that most human behaviour is learned through observing others through modelling and evaluating and drawing from this experience at a later date. An individual is more likely to adopt a modelled behaviour if they are similar to the model, the behaviour is seen to serve a valued purpose and the model is admired (Bandura, 1977). Gear et al. (1994) wrote about the benefits of role modelling as a means of learning tacit knowledge. Participants in the present study recognised the benefits of acquiring this subtle knowledge base. However, Nojima et al. (2003) warned about the over-reliance on knowledge that is not evidence based and described an expert nurse as one who utilises this to guide her nursing practice. Joubert et al. (2006) found that poor role models can have a negative emotional impact on medical students. They can lead to imitation and perpetuation of unhelpful behaviours and hamper the learning environment. In the present study, the participant who experienced a negative role model was trained many years ago. It is hopeful then that nurses in this study who are early in their career reported more positive role model experiences during their training. Although these findings cannot be generalised it is encouraging that they have had these experiences. It is also interesting that there was little mention of role models in the present work environment. Perhaps those nurses who have experienced the more traditional route of training are uncertain how to be a role model in an aspect of care they are uncertain about. This was found to be the case in Andrews & Chinton's (2000) research findings.

5.3 Personal Experience: Self

Some participants made the link between socially sanctioned forms of self-harm that they engaged in, such as smoking, with cutting as a means of relieving tension:

N1: ...you'd never let the child see your frustration...you might walk out of the room or go have a fag.

And later

N1: I think Deliberate Self-Harm is something people [use] to relieve frustration and relieve stress, you could say smoking is as well.

Personal experience is a useful resource to draw on in the absence of formal teaching but the level of understanding achieved is limited and at times may not always be reliable. Blanchard (1996) emphasised the need for research to inform practice to avoid approaches that reflected a 'trial and error' or 'well, we've always done it this way' approach to ensure standardised patient care.

5.3.1 Personal Experience: Others

The majority of nurses spoke about knowing someone in their personal life who self-harms. Some described this knowledge as being useful for increasing awareness whilst others still felt in the dark:

N7: ...we weren't aware for a long time that my friend was self harming ehm, we still don't talk about it openly, we still don't know if she feels comfortable speaking about it.

5.4 Training: Education

All participants highlighted a lack of mental health teaching in nurse training:

N5: ...it's so unknown to a lot of people I think it's a scary thing, it's like we all know about medical, we all know about surgical but not mental health, it's not in our training. It's just started to be brought into our training.

N6: We didn't cover any mental health stuff specifically. We looked at certain diseases and how that affects the patient psychologically as well. But we never looked into psych .. that's why I didn't expect to have to be dealing with stuff like that when I came here.

N3: ...so you're kind of doing a whistle stop tour of mental health.

Chapman (1999) highlights the need for nurses to gain sufficient theoretical as well as clinical experience. Inappropriate training placements and lack of appropriate teaching during training was spoken of most frequently in this study. Research carried out by Crawford and Kiger (1998) and Prater and Neatherlin (2001) support these findings. Professionals working with young people who self-harm in the Highlands were invited to attend one of four training day workshops in September 2005. An audit revealed that only 2 nurses working in a hospital setting were among 136 professionals in attendance (McGlynn, unpublished). None of the participants reported awareness of this training day and some cited an interest in acquiring further teaching:

N3: I would love to have more teaching on mental health.

This has implications for the provision of staff training and communication and accessibility of relevant courses.

5.5 Media

Most participants recounted a book, newspaper article, health promotion campaign, T.V. or radio interview that increased their understanding and awareness of the problem:

N4: The best thing I heard was, it was actually a radio programme on Radio 4 about self-harming and it was people who had sort of passed through it talking about their experiences and what they found helped or didn't help and you know just distraction techniques which still nobody actually comes up and says well why don't we try this.

N6: I just think that there seems to be a lot more research into how many teenagers are doing it. Y'know it's in the papers a lot. That's probably the main thing that

I've noticed. You see adverts, the 'See me' campaign, and all that mental health stuff but definitely the media's had a big influence. Not so much that there's been more emphasis for healthcare professionals. I think it's about tackling the general public's attitude.

Self-harm has received increased attention in the media since personal disclosures of celebrities, such as Princess Diana. This has been important in tackling this stigmatised behaviour (Fletcher & Hogg, 2001). Given the concerns about nurses lack of engagement with research (Pravikiff et al., 2005) the media may be a useful tool in arousing interest in an unfamiliar topic. Although Pedley and Arber (1997) describe interest as being an important motivating factor in learning, other factors such as time available and practical research skills also need to be considered (Pravikoff et al., 2005).

5.6 Patient Care

Participants talked about patient care in the past and present:

- N4:** In the early 90's....a girl who had cuts on her...at that time I think we used to dress them and clean them and dress them so that they were covered and it wasn't particularly needed but they were covered to stop you know to stop to cover up the skin so she couldn't do it again.
- N5:** ...a lassie had elastic bands that she flicked around her wrist so they were taken off her and I wasn't anything to do with that patient but I don't know how they managed to get the elastic bands off her without upsetting her.

McAllister et al. (2002) point out that a lack of formal training in self-harm is more likely to negatively impact on patient care, which in turn leads to patient dissatisfaction and a future avoidance of health services. Thus impacting on people seeking help if they feel suicidal and thereby impacting on mortality rates (Crawford & Wessely, 1998; Ryan et al., 1998). It is hopeful that patient care has evolved but it is alarming that a patient had a recognised useful distraction technique removed (National Inquiry, 2006).

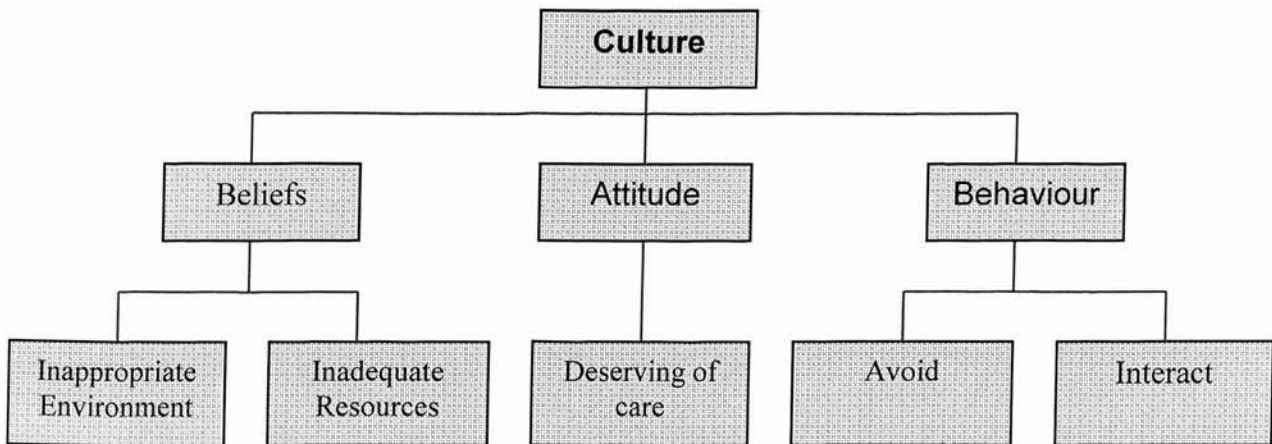


Figure: 6 Main Category: Culture

6.1 Culture

The majority of participants revealed beliefs about there being a high risk of people who self-harm attempting suicide on the ward. All interviewees stated that the Children's Ward was not an appropriate environment for young people who self-harm. This was considered from both the nurses' viewpoint and the perceived experience of the young person. It became apparent that some nurses enjoy interacting with these patients whilst others avoid them. Some beliefs and behaviours described represent negative attitudes held towards people who self-harm and their families.

6.2 Culture: Nurse Beliefs about Ward Setting

All participants talked about the Children's Ward being an inappropriate setting:

- N2:** I don't feel they're compatible in the same unit because I think that they these self-harmers will always lose out to the acutely sick child because, because of the fact that this just has to be done with a sick child it has to be done now you've always got the feeling that these ones can leave it but it's that inconsistency it's that I could talk to you now and give you an hour whereas tomorrow I might only have five minutes for you.
- N5:** ...most of the time we get them because there's just nowhere else for them to go. It's like limbo. It's like they can't be handled at home anymore and there's nowhere for them to go that's safe so it's just really for that reason so a lot of

the time it's just a bridge gap between here.

N7: I've always felt that here's not the place but then there's maybe nowhere else.

6.2.1 Culture: Nurse Beliefs about a Young Person's Experience on the Ward

Beliefs about the young persons experience on the ward highlights a lack of resources available:

N4: ...its terrible...kids put in 6 bedded rooms with crying babies, so so bad for them...it must be horrendous being there as a patient.

N6: I imagine there would be no privacy.

N2: I can think of a couple of them in particular that...found it quite distressing being in the ward where they were really there with smaller children who had their mums there all the time and they were sitting there thinking 'cos their relationships were failed relationships with their mothers.. and seeing these little children who were being loved and doted on by their parents.

Anderson et al. (2003) similarly found that staff caring for people on a medical ward who had attempted suicide found the setting non-therapeutic for their patients. They expressed the view that as they were unable to treat the behaviour as an illness; it undermined the objective of their role. Participants in the present study also questioned their role in these patients care. However, respondents also considered the inappropriateness of the setting from the young person's perspective. They offered relevant insights into pertinent issues, such as the lack of privacy and consistency of care, which were highlighted as a source of distress for young people admitted to a psychiatric ward after self-harm (Spandler et al., 1996).

6.3 Culture: Attitudes of Professionals towards People who Self-Harm

Some talked about attitudes held by other healthcare professionals that they've encountered:

N3: ...she [patient who self-harms] went to theatre ehm the anaesthetist and surgeons there [said] made a comment about how she was dirty and how mum

was over fussing and how was the mum crying and it was all this big drama....they just sort of thought oh well she's just a third rate citizen

N2: She [nurse] worked in the surgical, adult surgical and she started going on about these people and how they have to go to surgery and get sutured and what a waste of money it was.. the way she said it was as if we would all go oh yes you know I think you're right.

N4: ...there's also a group of nurses [psychiatric nurses] who I don't know they seem to blame patients, it's their fault that they're in here [psychiatric hospital] and often it's not.

Vivekananda (2000) found that the general public's attitude towards self-harm at the beginning of this decade was negative. Earlier research by Mavundla and Uys (1997) pointed out that healthcare professionals are not immune to negative attitudes held by the public. These attitudes can lead to feelings of helplessness which can impact on the provision of care (Murray & Steffen, 1999). Interestingly, Read and Law (1999) also found in their research that mental health professionals can have the same social prejudices as people employed outside of healthcare. The findings reflect Anderson's (1997) assertion about the value judgement that can be imposed between the 'deserving sick' and those who bring 'sickness' upon them self. This poses the question about the effectiveness of mental health awareness campaigns on societal and professional attitudes.

6.3.1 Culture: Attitudes about Perceived Risk of Care and Attitude Transformation

A number of participants revealed the perceived risk involved in caring for this patient group:

N5: ...they [other nurses] seem to think it'll [self-harm] lead to something more serious and it doesn't always...they don't know if something could happen and it's a responsibility that we've got it's just we want them shifted out because it's easier really.

One participant spoke about an attitude transformation achieved through gaining work experience in a different setting:

N1: [I thought] they weren't doing it properly as I said you go longways not crossways....and sometimes you felt so frustrated you felt like saying listen it's long ways love if you want to do some damage, stop this going across, you're just you're just scarring yourself! A&E gave more of an insight into it.

Self-harm and suicide are difficult to distinguish, particularly given that research indicated that half of all young people who commit suicide had a history of self-harm behaviour in the preceding year (The Samaritans, 2001). It is not surprising then that participants conveyed a sense of uncertainty about the purpose of self-harm and wished for them to be removed from the ward. It is hopeful that knowledge gained through experience led to greater insight.

6.3.2 Culture: Attitudes about Young People who Self-Harm and their Family

Views about the individual and their family were also conveyed:

N2: ...my own opinion is that they're very damaged children and by the time they get to us I feel that that damage, it's too late.

N5: ...some of them are not so much mental health, it's more a cry for help, or they're playing up for their parents.

N4: You just tend to think the parents aren't very parental.

Slaven and Kisely (2002) found that hospital staff were perceived by mental health workers to have judgemental attitudes towards patients who self-harm. House et al. (1998) found that health professionals commonly perceive people who self-harm as having a poor prognosis, particularly when the individual is seen to repeatedly self-harm. This was evident in some of the participants' narratives. This can lead to feelings of inadequacy and uncertainty, which can be communicated to patients if not tackled (Malone, 1996). Emrich et al. (2003) describe how attitudes influence both personal and professional behaviour.

6.4 Culture: Behaviour – Challenging Negative Attitudes of Others

Some participants talked about challenging negative attitudes:

- N3:** ...the other student ehm stuck up for her [patient who self-harms] and said [to surgical staff making unhelpful comments] actually this girl suffers from mental health issues and there's a huge complex family background so it's a good sign mum's fussing like that not a bad sign, I don't think it's appropriate for you to be talking about her in that kind of way.

6.4.1 Culture: Nurse Behaviour towards Patients

Participants talked about other nurses' behaviour towards the young person and their family:

- N2:** ...they don't offer these people even courtesy you know sort of simple things like that they treat their family, their friends and family disrespectfully, things like that would be the negative, sort of just a general disrespect for the other person as an individual...'cos you know there's, you know, 'you're coming in here self-harming and I don't need to respect you and who you are or who your family is' or that sort of thing that's kind of sort of a general sort of way of putting it I think.
- N4:** I think now it's slightly more understanding before they used to be, sort of the nurses who didn't like dealing with them, would see them as a waste of time and attention seeking and totally unsympathetic but you are always going to get that somewhere like here.

The NICE guidelines on the short-term management of patients who self-harm (2004) highlight the need for professionals to show respect and understanding to people who self-harm and their families. These recommendations highlight that families may also be experiencing distress and anxiety and need emotional support.

Vigilant behaviour is described by participants who believe they are protecting patients from further harm. This is discussed in the principal category 'Catch 22'.

Participants talked about avoidance behaviour:

- N3:** I know a lot of people avoid them when they come on the ward.
- N4:** I think a lot of people pass it on or they'll write it down [on noticing scars].....yeah, and they report it to the next staff nurse but they'll not actually say anything to the person.
- N2:** [I] definitely think that some people say 'oh don't give me that' or 'don't give me them' or you know 'don't give them to them because they don't like these sort of types of patients'.

Hemmings (1999) described how a nurse's feeling of frustration that may arise from not being able to cure a patient who self-harms may be expressed through their behaviour and demeanour. This can be interpreted by the patient as rejecting and act as a trigger to further self-harm. The present study's findings reflect avoidance behaviour through patient delegation and by not addressing issues with the patient directly.

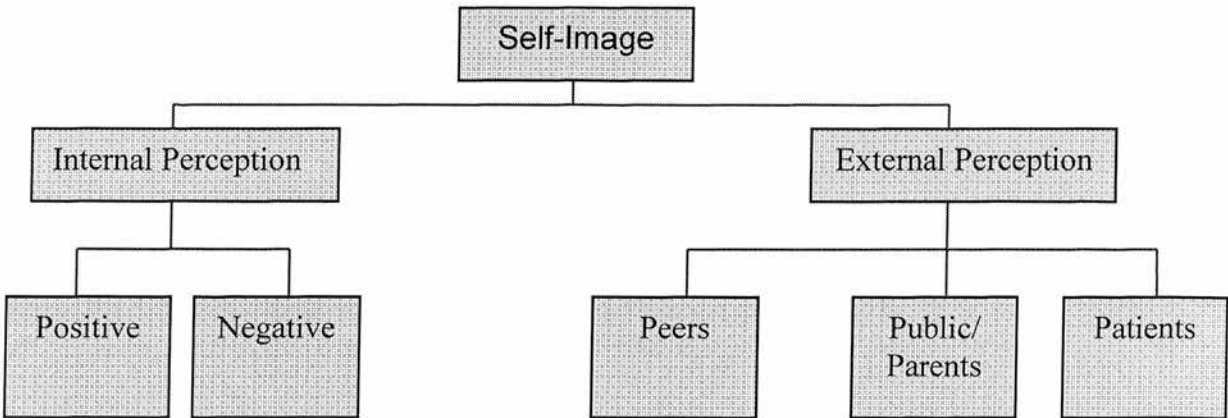


Figure: 7. Main Category: Self-Image

7.1 Self-Image

Internal and external factors appeared to influence participants' concept of self-image in their role as a nurse. Job satisfaction was derived from working within a perceived comfort zone. Feeling disliked through patient interaction and not gaining a sense of achievement through their work were negative factors discussed. Criticism from others,

performing a job in the public eye and a lack of engagement from the patient are aspects considered in terms of influencing external perception.

7.2 Internal Perception: Positive

Some participants remarked on a sense of job satisfaction working with young people who self-harm:

N4: I mean to me it's sensible, you would look after what you think you are better at and I'm much better at dealing with troubled teenagers than I am with children who aren't breathing.

N3: ..working with kids with learning disabilities and the kind of overlap between learning difficulties and mental health and things like that; all the sort of social work, child protection things and just I find it really interesting....I like them all and when they cross over like its so nice, when they come into hospital you know a little bit about them already.

7.2.1 Internal Perception: Negative

Other participants commented on the difficulty of not being liked and not gaining job satisfaction:

N1: Well, it's hard not to be liked. She mightn't open up to me in the same way as she would to a girl that trusts her. You want your patients not to like you but you want.. you want to have a relationship with them, and you want them to be able to tell you just as much as [they] tell anybody else 'cos you have to be able to help them.

N5: I never ever think that that it's really positive, that the nurses are enjoying working with the patients who self harm.. that they feel like they're getting somewhere. It's just that we want them out of here.

N2: ..they'll say I don't want [nurses name deleted] today I want [nurses name deleted] or something.

Adams et al. (2000) found that nurses who are expected to expand their role can experience a greater sense of job satisfaction but in the absence of professional recognition, other nurses may find it decreases job satisfaction. The congruence between

an individual and their work environment is an influencing factor (Taris & Feji, 2001) which is discussed in greater detail in main category 'Type of nurse'. Extrinsic factors such as an inappropriate skill mix and increasing complexity of care are also cited as important aspects to job satisfaction (Tummers et al., 2002). In the present study, participants who enjoyed diverse training placements were more likely to welcome the challenge of caring for patients who self-harm on the Children's Ward. Perhaps their experience of caring for patients with a different objective i.e. not 'fixing' allows them to see their input as still being worthwhile. Rayner et al. (2005) explained how nurses' negative automatic thoughts can be activated by an unhelpful interaction with a patient. They reported that nurses can feel disliked when the patient does not engage with them and find it particularly hurtful when they chose another nurse in favour of them. The findings of this study also reflect those results.

7.3 External Perception: Peers

Timmins et al. (2005) found in their study that nurses rated the act of giving compliments to fellow nursing colleagues highly. Participants in this study gave no mention to this type of positive feedback, which may explain why some participants had no sense of being useful in their role when caring for patients who self-harm. This may be an untapped resource among the ward to boost morale and increase job satisfaction. Peer support is discussed further in main category 'Support mechanisms'.

7.3.1 External Perception: Public/parents

Participants carry out their job in view of others which leaves them open to being judged:

N8: I did have one and you're standing outside the toilet and they'd locked themselves in the toilet, and you're like come on now and you can hear them rubbing their wrists off the toilet thing, and it's like just don't hurt yourself and come out and we can talk and discuss this, and they're like 'no' and there's other parents watching in the room while you're doing it, and you're sitting there and it's just like if I could be swallowed up now, the little shite get out of here and talk to me... I'll be sitting there going, and I mean there.. was

two of us....it was stressful because you were aware of the other parents. I mean the child's telling you to 'fuck off' and you were quite aware of the fact that she's hurling abuse at you....[parents] make their own little comments but you just let it go over your head.

- N1:** They'd [parents of other children on ward] want to know what's wrong with her [patient who self-harms with no physical signs of illness]... Why do you have to spend so much time with that kid?
- N6:** A lot of them smoke, which is quite difficult for us...we're thinking y'know it's a children's ward and we're standing outside with under 16's and...we're looking like we're promoting it. We're trying to decide how ...we're using the no smoking ban to stop that. Well, it's like you either take them out or they're going to abscond.

7.3.2 External Perception: Patients

- N1:** ...because she [young person who tried to hang herself on ward] knew I was one of the nurses who had helped [resuscitate] her when I went back on day shift she was, she wouldn't talk to me, she was very withdrawn... eventually it just got to the stage where ...you know, we all, the four of us who were involved that night sat down and chatted to her and just said you know we had to do it, we, we couldn't have allowed you to do that on the ward and what about all those other children who would have seen you and you would have been gone the next day and what about your family and your friends and everyone.
- N2:** ...you might be a wee bit quiet, you talk away with them [patients who self-harm] and then the day gets really really busy and they come up and say can they have a bit of toast or can they have ... and you're thinking Oh God you want me to do toast! And it's sort of prioritizing everything and not like I'm saying you'd turn round and you're rude or anything like that but you're like that's not really that important to me because my priorities have changed since the morning when I had lots of time but now I've got to do this, this and this so I'm not wanting to ... asking for toast is putting pressure on.
- N8:** ...you'll get nothing from them, you can sit there and try to sit and you know 'I'm here if you need to talk' and they're looking through you, at you, over to the window, whatever ehm but the next time you come in or the next shift you might come back on you might get like a recognition of them.

Siebens (2006) found that positive self-image in a study of nurses was found to be related to supportive management, effective teamwork, adequate time to perform duties and societal recognition. Nurses in that study reported that these factors are absent from their daily practice. Many participants in the present study talked about having

insufficient time to meet the needs of patients on the ward and feeling pressured as a result. Percival (2001:22) found that nurses are viewed as being ‘nice’ people and states that ‘nice people often accommodate other people above themselves and adapt their behaviour to match what they think people expect of them’. Being on view to the public as a nurse performs her role could then heighten the emotional labour of keeping her feelings contained.

Balling & MacCubbin (2001) stated that parents whose children are in hospital can become confused about their role and even consider themselves as staff members, scrutinising every action and questioning the competence of others. The impact of parents’ presence on the ward was highlighted in the present study. It is interesting that the nurses felt they needed to justify their care to the young girl who attempted suicide on the ward. This research highlights the difficulty that may arise for a nurse attaining job satisfaction when her self-image is perceived to be challenged by a number of different sources.

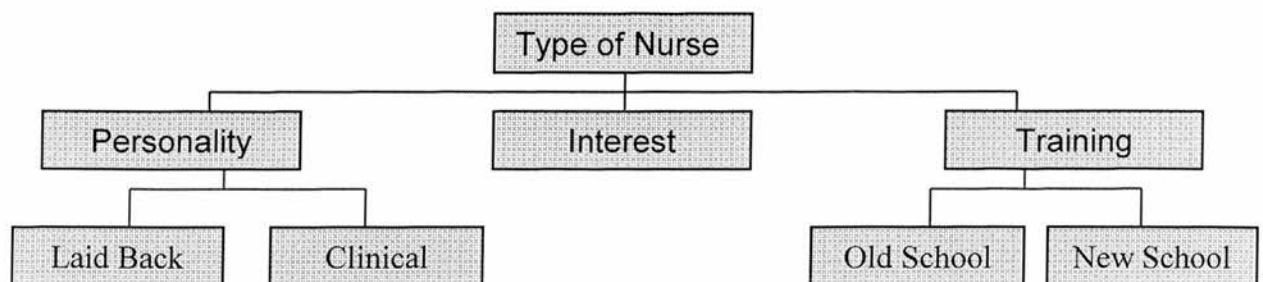


Figure: 8 Principal Category: Type of Nurse

8.1 **Type of Nurse**

Some participants commented on personality and made a distinction between laid back nurses who enjoy a slower pace of work compared to ‘clinical’ nurses. Nurses who were described as being laid back were considered by participants as better matched to the care of young people who self-harm. Level of interest displayed in the issue of self-harm

was also a contributing factor to nurse type/behaviour in regards to level of engagement with the patient. A distinction was also made between nurses early in their career and those who had been trained many years ago, termed 'old school' nurses. Differences in training, experience acquired, role modelling and practice were discussed.

8.2 Type of Nurse: Personality

Participants spoke about different traits they possessed such as optimism, enthusiasm and confidence which helped them relate to young people. Further to this, a number of nurses made a distinction between types of nurse:

- N4:** ...you've got the clinical nurse whose clean, tidy, organised into emergency care...who love it when things happen...I'm not.
- N2:** The pace. It was slower which suited me eh suited me better but then maybe the pace of working in paed's suits me better cos you get a lot of *satisfaction* from quick results but in psychiatry you're not going to get a quick fix.
- N8:** I'm too much of the organised efficiency kind of A, B, C, D, E, F, whereas if you stick a psychiatric patient in there they're going to be interfering with my sense of organisation for that day and they've actually stressed me before I've actually looked after them because because I physically work they don't fit into it it's like they put me out of key before I even start.

Sand (2003) described how a choice in career is based on different motives for different people. In regards to nursing, some people may have chosen a career in this profession because of a caring personality but also a drive to seek confirmation of their worth through the rewards inherent in this type of work. Vroom (1995) described examples of rewards that can be gained in nursing, such as social communication, intellectual enlightenment and a sense of being useful and appreciated. The present study illuminated that personality had a bearing on what aspects of the role were considered rewarding and thus gave a sense of job satisfaction.

8.3 Type of Nurse: Interest

- N3:** I love mental health and I love child protection, I love like community children's nursing and learning difficulties.
- N5:** Ach no, it's getting better. A lot better. I think because there's more of us that are interested in it now cause there's a couple of new girls that are interested in it as well.

Eraut et al. (2004) asserted that an individual needs to be committed to the value of attaining specific knowledge if they are truly to engage and benefit from the learning process. As the present study indicates some nurses are interested in mental health care in the context of paediatric medicine which is encouraging in terms of their commitment to learning and the gains that can then be achieved.

8.4 Type of Nurse: Training – 'Old School' versus 'New School'

Another important aspect raised was training.

- N5:** I'm not saying we are experts but we know a bit more and have an interest in it as well. It's it's still...[sighs].. the older staff I think they are still finding it difficult but the ones that are newer that are coming on to work after me its fine cos you tell it to them and they just take it on as new. Yeah..Ach but it is coming on its just slow, like anything once you're set in your ways about doing certain things it can be difficult to change it.
- N3:** I think some of the old school nurses, the older ones of the nurses on the ward...they don't regard it as a problem.
- N2:** ...people that are in more senior positions really [feel the] need to have sort of answers 'cos these, these people [newly trained nurses] have been trained differently 'cos they're trained to ask questions and not just to accept everything... they're far more encouraged to you know do things evidence based and sort of *ask questions* you know, 'why are we doing this and why aren't we doing this'.

Individuals commonly feel a sense of personal threat when change is introduced (Esty, 1987). The integration of nursing education into the university system has led to a division between the skilled practice nurse and the educated nurse (Wakefield, 2000). Gillespie et al (2006) say that professional jealousy may account for this divide. The findings of the present study suggest that it is a lack of knowledge that may explain the

difference in interest and understanding regarding self-harm. Lee-Hsieh et al. (2003) found that nurses can avoid asking questions of their younger colleagues for fear of 'losing face' in front of them. Being a role model may prove challenging as a result as it is commonplace for the more experienced nurse to be the more knowledgeable one, however, the roles may be reversed when newer nurses have acquired different teaching unfamiliar to their more senior colleagues.

Timmins et al (2005) stated that nurses are regarded as being in a subservient role which can impact negatively on the development of assertiveness skills. A number of participants referred to other nurses confidence in asking questions, and training was described by participants as assisting people in developing this skill:

N4: Yeah it [training] does give you confidence....I don't feel so bad saying why did you do that you know a lot people don't.

A number of participants talked about having been protected from mental health cases when they completed their training some years ago:

N2: I didn't actually see self-harm in kids during training when I did paed's so there was a special unit, a child and adolescent psychiatric unit that they were sent to...it was bit secret a secret place [psych unit] students weren't allowed near it just qualified staff.

Experiences that involved protecting staff from this patient group appear to still influence modern day practice:

N1: ...staff mightn't give you [student nurse] that child because they don't want you to mess up. You might mess up this kid's head even more. I don't think they would.

The perception that these young patients are risky to take care off only serves to perpetuate the stigma surrounding the issue. Hawton et al. (2006) explain that stigma that is associated with mental illness is a contributing factor in the under-utilisation of health services and needs to be addressed to ensure people seek help when they need it.

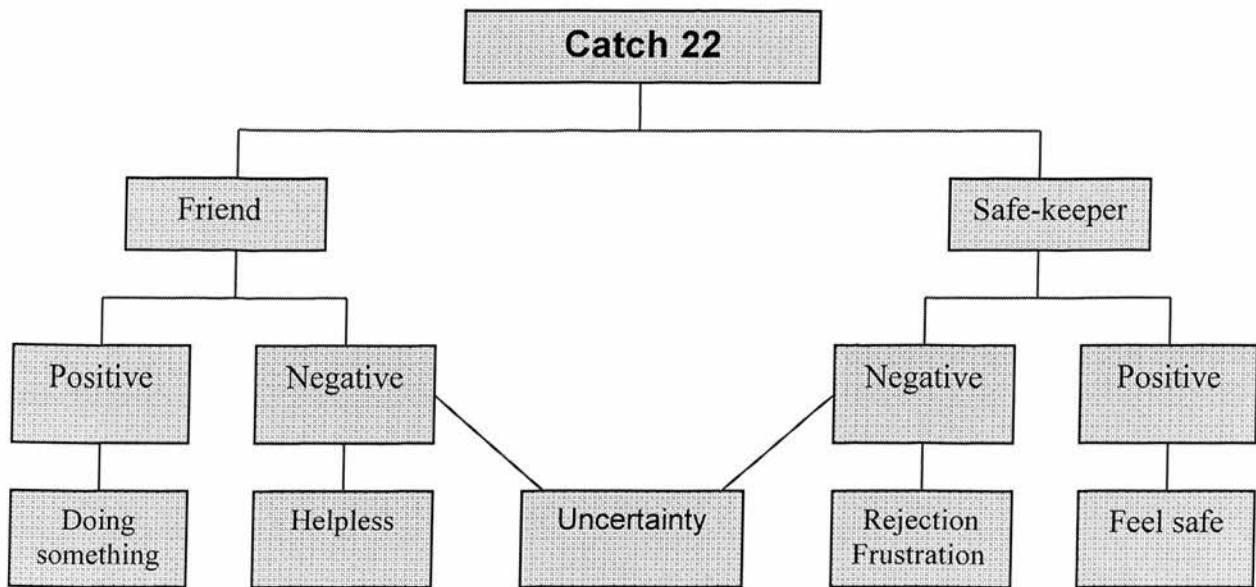


Figure: 9 Principal Category: Catch 22.

9.1 Catch 22

Participants found it difficult to juggle the two roles of being a friend which increased the likelihood of the individual speaking to them and being a safe-keeper where they were more confident that the young person was safe from harm. This left many in a 'Catch 22' position trying to balance these opposing roles. Participants describe both roles having the potential to lead to them experiencing further uncertainty:

9.2 Catch 22: Role of Friend

- N1:** I probably didn't have as good a relationship with her as people who did trust her and she knew that they trusted her but then they take the piss out of people that trust them as well so you have it two ways...so you've got a Catch 22 don't you? You've got the strictness of having to do the job but you've also got, sort of be their friend as well. So you kinda think you've really got to be one way or the other it's very difficult to be both.
- N5:** It is awkward....Yeah it can be really difficult, especially if you were their key nurse because that's the initial thing you're diving straight in to take all their stuff off them and then [laughs] do you want to talk to me. It usually takes a while.

9.3 Catch 22: Role of Safe-Keeper

- N8:** The first time [young person who self-harm absconds] is really stressful because you do feel this utter responsibility that they're going to go and kill themselves and it's on my shift and I shouldn't have let it happen and they ran away and it's like no, I physically can't handcuff them to the bed so it's their choice to leave but they're informed that if they do we'll just call the Police.
- N2:** ...there's so many things in a hospital that could be dangerous to somebody and that really for our protection almost, we wanted to have these people watched all the time.

People taking legal action against National Health Services Trusts on claims of alleged negligence by nursing and medical staff in cases of suicide and self-harm is becoming increasingly more prevalent (Gournay & Bowers, 2000). Fieldman (1988) highlighted in much earlier research that ethical and professional dilemmas are common when caring for someone who self-harms. There is a sense of fear of participants in the present study of the young person harming themselves and the implications for staff.

9.4 Catch 22: Emotions Evoked in Nurses when Adopting these Roles

Participants said that it was common practice on this ward to search and remove possessions that a young person could use to harm them selves. This evokes different emotions in staff:

- N8:** But I mean we've had them come in and sit there and go they haven't got anything, you're like can I search the stuff, yeah fine, and then at visiting time the next day their friend comes in and gives them a nice sharp blade.
- N4:** ...some nurses, they do freak, they don't like searching belongings, just every possible thing that she could hurt herself or anyone could hurt themselves with they would try and take away...I sort of played it down rather than searching everything and taking everything away...people do..could use absolutely anything.
- N2:** ...we're doing it because it's the way we feel it safe within our area.

Nichols & Mallon (2006) suggest three separate psychological factors that play a role in moral reasoning: rule representation, cost/benefit analysis and emotions engendered. Searching, checking and removing personal belongings are not typical nursing duties but if the young person is considered suicidal then the benefit of such actions may counter any negative feelings experienced. However, if a nurse is knowledgeable about self-harm they may find the protocol more difficult to justify. Participants revealed not feeling in control, which is an important aspect of feeling safe in a work situation (Boey, 1999). Carrying out these duties may help increase a sense of control but when it proves ineffective, participants described feelings of resentment that the patient had violated their trust. Rayner et al. (2005) proposed that this situation can lead to rejection and withdrawal from the patient prompting further self-harm.

Participants talked about 'Stepping on untreaded waters' when interacting with a patient and the uncertainty involved:

- N6:** I think it's a double edged sword cos if they did come and speak to you it would be easier but then obviously if they disclose anything, that brings out other things that can make it more difficult but then if they are being really quiet and they're not telling me anything I can think that can be just as difficult so...you don't which is better.
- N4:** Em probably they're [other nurses] just scared that they don't know how to, scared in case they're going to offend them [young person who self-harms] or hurt they're feelings, I don't know ...stepping on untreaded waters...get to the bottom of something they don't know how to deal with fear in case they get involved in something they can't deal with.

Participants revealed the perceived costs and the benefits of talking to a young person who self-harms:

- N6:** I think by talking I feel like I'm doing something.

And later

- N6:** I get the impression we feel like were in the same boat...feeling a bit uncertain..... In a way with a child protection case it might be more straight forward cos there's a protocol.
- N8:** ...you feel some sort of a failure 'cos you couldn't get that bond and you couldn't get that rapport going.
- N1:** I knew why she felt the way she did which was just frustrating cos she wouldn't talk to me and then I couldn't help her.
- N8:** ...as long as you stay on the superficial basis they're quite safe and you're quite safe because you really don't want to go where it's unsafe territory and they start talking to you about things that are ehm threatening.

Anderson et al. (2003) found that medical staff rated patient safety above the patient alliance for young people in their care who had made a suicide attempt. In the present study there was a conflict between juggling these two roles as not all participants viewed self-harm in terms of suicide. Worries about accountability seemed to play a crucial role in making this juggling act more difficult. Participants talked about feelings of uncertainty which can arise as a result of adopting either role which gives the impression of a continued sense of helplessness.

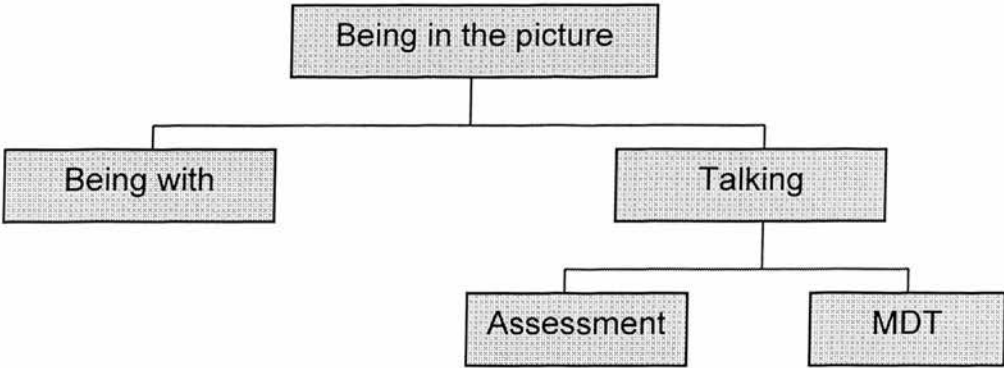


Figure: 10. Principal Category: Being in the Picture

10.1 Being in the Picture

Participants revealed difficulties they encountered in understanding the young person's perspective. A number of interviewees mentioned the awkwardness involved in engaging with the young person. Many found the suicidal risk assessment measure unreliable; as they were left to use their judgement in the absence of the young person speaking to them. There was also a sense of being left out of the picture by other professionals involved in their patient's care. Some participants recognised that being with a patient in a non-intrusive way could be useful and lead to insight about the young person's situation:

10.2 Being in the Picture: Being With

- N7:** I think because I'm interested, I think if I wasn't I wouldn't bother asking but ehm and you know they might not say anything they might not want to, which is fine, or they might want to, you know it'd be great if they did.
- N3:** I think if you come across all overbearing and sort of say, 'this is what you need to do and if you don't do it then this is going to happen'. They just think that, you know, 'well they don't care' kind of way but if you just go in and chat to them or even not say anything and sit with them quite often they'll come out with things.

Martin et al. (2006) found that respect, time shared and openness in a helpful adult are valued by a young person in helping to form an alliance. Cooper et al. (2005) wrote about the value of letting a patient's story evolve in their own time. It is encouraging that a number of nurses care for their patients in a manner which reflects this approach.

10.3 Being in the Picture: Talking

Participants revealed difficulties engaging with patients who self-harm:

- N7:** I suppose the difficulty is the teenager bit and how much they want to talk but ehm that could beYeah some come in with attitude, yeah it does make it a wee bit more difficult, maybe a wee bit more challenging.

And later

- N7:** I do find them interesting, it's just getting the time to spend with them to sit and speak and feel comfortable about it, it depends if they're comfortable speaking about it as well but I do enjoy spending the time if I have it you know.
- N8:** But they're more awkward and you just sit and think this is what every teenager parents' nightmare is 'cos they just wont talk to you and they're sitting there with their arms folded and we've had them say, 'I'm leaving'.

As young people differ from adults in their ability to cognitively understand their problems (Oetzel & Scherer, 2003), it follows then that they may experience difficulty articulating these issues. Foote (1997) found that young people admitted to a medical ward are sometimes perceived by staff as being difficult to engage with; as the present findings demonstrate. McGaughey's (1995) earlier research found that a young person's difficulty in communicating may impact on the effectiveness of professional intervention. In the present study the engagement is described by a number of participants as being awkward because of their age and the problem that has led to their admission.

Participants described not having a clear sense of the young person's predicament:

- N3:** ...we're generally not in the room when they speak to [psychiatry] in on their own or in with the parent and usually they sort of feedback after they come out. There's not then a huge amount of people in the room to say, 'why did you do this?' and that sort of thing so they usually come out with feedback to us.
- N5:** ...then it was kinda fed back so it was really good.

There is a sense of acquiring an unsatisfying amount of feedback for participants in this study. Spandler (1996) illustrated that some young people are able to identify a causal link that explains their self-harm but many stated that self-harm can serve different purposes at different times and the causal relationship is not clear. Many participants in this study believed psychiatry were able to establish an answer to this question and, as such, are likely to feel disappointed by the feedback. They seek to understand the young

person's perspective but are not aided by the limited information communicated from psychiatry. Increased awareness about a young persons motivations and the possible uncertainty surrounding this issue for each individual needs to be highlighted.

A number of nurses talked about the difficulty with assessment:

- N6:** I do think it's quite subjective cos sometimes you think, 'oh I don't know if they are feeling that or not cos they haven't said'....But the decision lies with you.
- N8:** ...they won't talk to you so you can't particularly assess them 'cos we have our own wee risk assessment to take but if they're actually not going to talk to you if they're not going to say anything then you're going to have to put them on a higher score .

Cooper (1998) explained that it is an important duty for nurses to gather information that assists in the risk assessment of a young person particularly if there can be a delay in attaining support from specialist services, as is the case in the present study where there is no 24 hour child psychiatry cover. The NICE (2004:28) guidelines recommend that all healthcare workers who undertake assessment should be properly trained and supervised. Crawford et al. (1998) found that a one-hour teaching session can successfully instil confidence in completing an accurate assessment. In the present study, participants reported feeling unsure about this process, which could be tackled through the introduction of a short training session.

11.1 Model of Support Resources

Early research undertaken by House (1981) described social support as consisting of four important components: emotional support (feeling appreciated), appraisal support (social comparison and feedback), informational support (practical skills) and instrumental support (practical help).

Participants revealed a number of resources that they believed to be lacking and which contributed to unpleasant emotional states that can arise in response to caring for a

young person who self-harms. Social support appears to have a significant impact on coping with uncertainty (Billing & Tajfel, 1983).

The Conservation of Resources (COR) Model (Hobfoll, 1988, 1989) proposes that social support is a primary means of acquiring resources, as well as being a method of depleting them. An individual who feels supported is likely to feel competent to perform their role, which will influence a person's perception of their capability to cope with stress and feel in control (Billing & Tajfel, 1983).

The COR model incorporates a number of other stress theories and proposes that an individual seeks to gain and maintain resources, personal characteristics (self-esteem), conditions (being a nurse) and energies (time, money, knowledge). Stress occurs when there is a loss of resources or a threat of loss. For example, conflict may arise when an individual feels ill equipped to meet the demands of a task, this can lead to job dissatisfaction and anxiety. A resource that is thought to moderate these effects is an individual's sense of self-esteem.

Findings of the present study are reflected in the COR model. Personal characteristic resources such as self-image and interest in the subject matter of self-harm were discussed in the present study. Condition resources reflect the nurse's experience of fulfilling her role in a context that is not deemed appropriate to meet the needs of young people who self-harm. Training and work experience, juggling different demands, support mechanisms and organisational issues in the ward culture all influence a nurse's experience of being a nurse. The final resource relates to energies and the time, knowledge and practical skills that are available to nurses.

The COR model asserts that people have an instinctual drive to conserve and renew personal resources in order to cope with stressful situations. When an individual's

resources change, it influences their perceived level of control, which impacts on stress and ability to cope. Adapting to a situation is influenced by control-promoting and control-inhibiting behaviour. Resources that allow a person to feel in control promotes their adaptation to a situation and reduces stress (Hobfoll & Freedy, 1993).

Within the present study, it became apparent that avoidance strategies were employed by a number of nurses when faced with a young person who self-harms, which in the short-term reflects a control-promoting strategy but is in fact representative of a control inhibiting behaviour in the long-term. Avoidance strategies are considered anxiety maintaining factors from a cognitive behavioural perspective, as the individual deprives themselves of the opportunity to learn new skills through exposure (Kirk, 2004). However, the perceived threat that arises when dealing with a young person who self-harms is not necessarily unrealistic given the nurses' perceived lack of skill and the participants' general consensus that the Children's Ward is not an appropriate setting to meet the needs of patients with mental health problems.

Hobfoll (1988, 1989) stated that social support needed to be considered in context of other factors, such as status, education and knowledge about the stressful situation. The present research highlights issues that have arisen as a result of changes in nurse training and implications on ward practice that differ from a more traditional approach.

The core category and the four main categories which subsume the principal categories are illustrated in Figure 11 below. This is a reflection of the nurses' present experience which contributes and maintains their sense of uncertainty when caring for young people who self-harm. Figure 12 illustrates the Model of Support Resources which suggests a means of progressing forward to a state of increased security which would see nurses move from 'Stepping on untreaded waters' to 'Stepping on safer waters'.

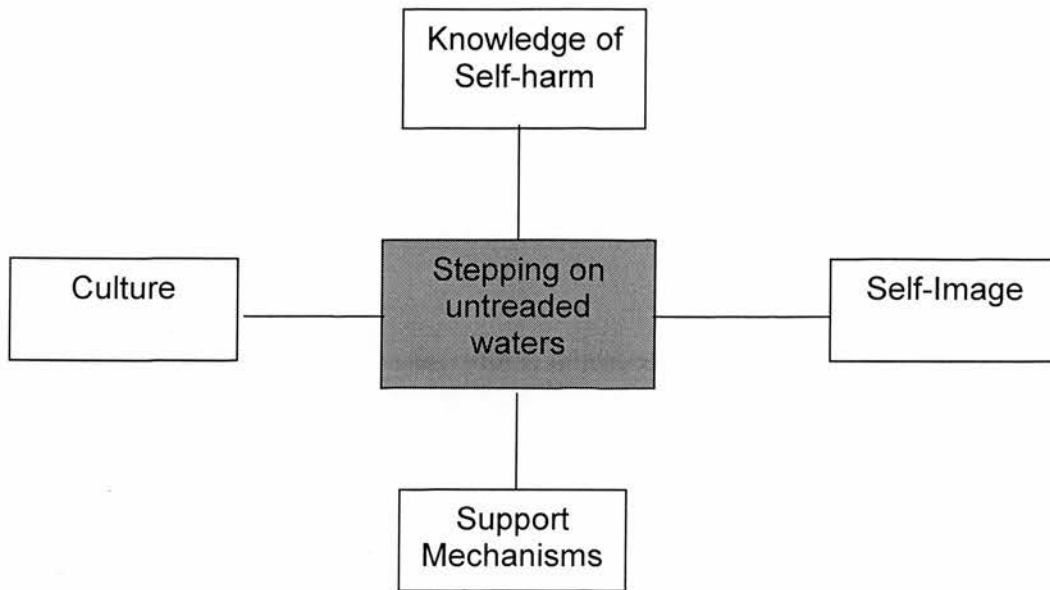


Figure 11: Resources available to nurses to assist them to cope with the experience of caring for young people who self-harm.

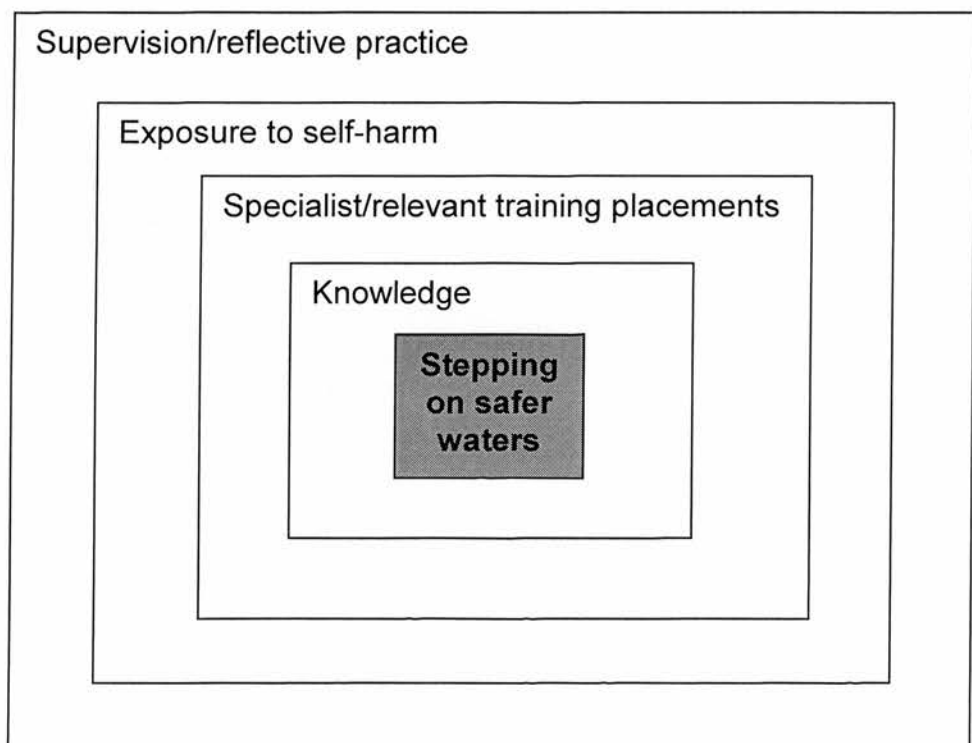


Figure: 12 Model of Support Resources: Means of increasing resource availability to facilitate nurses sense of control and safety.

All participants expressed a desire to increase their knowledge of paediatric mental health. It was interesting to note that a nurse commented, during the member check, that there are no mental health or psychiatric textbooks to refer to on the ward. Nurse training and education is evolving but those who have experienced newer models of training still report not having sufficient knowledge to meet their needs in managing the care of patients with mental health issues. Knowledge acquisition forms the centre of the model and has a ripple effect on the other three elements. Specialist/relevant training placements are considered critical in ensuring that knowledge, skills and awareness are achieved. A tendency of experienced nurses to protect junior nurses from patients who self-harm was conveyed. A need to increase exposure through work experience in the Accident and Emergency departments on weekend nights was recommended by one participant. Tackling avoidance behaviour of nurses who dislike engaging with young people who self-harm is critical in increasing awareness, confidence and nurse morale. Supervision/ reflective practice forms the supportive wall around which all other elements are contained and facilitated effectively.

A number of participant comments are reflected in this model:

- N3:** I just don't think, don't think nurses are trained enough to deal with mental health illness...I don't think that they realise it's such a problem.
- N5:** Yeah, even as a student I didn't have a mental health placement I had a Learning Disabilities placement but it wasn't quite the same. So I didn't really encounter anything until I came to work here so I came here straight after my training.
- N1:** I think they [student nurses] should also spend time in A & E where they should do days and nights. Whereas students unfortunately, students only work from 9 to 4 and they're off at weekends so they don't see it [self-harm].
- N4:** Reflective practice. That is really something we're lacking here.

Cohen and Wills (1985:314) proposed the Match Hypothesis in that support mechanisms prove most effective when there is a “reasonable match between the coping requirements and the available support.” An individual experiencing social stress should gain most advantage from social support. For example, an individual who has a difficult encounter with her supervisor is likely to find support from a fellow colleague helpful as it can re-establish her self-image as a skilled worker. However, Peeters (1994) found that under certain circumstances social support may have a negative consequence. As in the present study, the offer of social support can be interpreted as poor performance and can be threatening and lead to a reduction in self-esteem. This reflects back to Yegdich (1999) assertion that the aims and purpose of supervision, whether peer, uniprofessional or multiprofessional, must be made explicit to be effective.

Knowledge, training and experience are all important factors in contributing to a person’s perceived level of control. This has the potential to enhance self-efficacy, which Bandura (1986) described as a person’s perceived ability to perform a behaviour. This is also illustrated in the Theory of Planned Behaviour (Ajzen, 1991), which proposes that an individual’s sense of control, a positive attitude towards a behaviour (positive expected outcome) and influence of subjective norm (perceived behavioural expectation of others and perceived pressure to engage in an action) influences how likely a person is to engage in a given behaviour. In the present study, a number of participants revealed a sense of hopelessness regarding a young person’s prognosis. According to this model, challenging this particular belief could lead to a greater propensity to interact with a patient who would have previously been avoided and feared.

The present model of support resources when considered in line with the COR Model, Match Hypothesis, Theory of Planned Behaviour and self-efficacy illuminate how the present debilitating sense of nurse’s feelings of uncertainty can be challenged; thereby increasing confidence and influencing patient care.

12.1 Confirmability of the Present Findings

Three participants were chosen at random to offer their feedback on the results of the present study. This offered them the opportunity to reflect on the findings to assess whether the proposed model resonated with their experiences. This process known as member checking, enhances the credibility of the findings as it highlights whether the results are representative of a shared reality.

The member check sessions revealed participants overall agreement with the findings and offered further valuable insight into the subject matter:

- N8:** Uh-huh, yeah that fits together well. There's definitely a need for more support. You know even if we were told at the end of a busy day that our work was appreciated. I know you're getting paid for doing a job but I it would make a real difference to be thanked at the end of a busy shift but not everyone recognises that. I think as professionals they don't think you need that type of feedback.
- N5:** I see what you're saying about all the uncertainty. There's not even a psychiatric text book on the ward. If a child was coming in to us with a medical, with a physical problem, we could access the paed database and know what to expect and what we were dealing with but there's no where to check here. You could be on shift and not one of us even has access to the Internet. There's patient information sheets for kids and parents but there's nothing for staff. There's no easy to read guidelines or tips or anything.
- N1:** That sums it up. In a way people who are known to be interested in certain areas are thought of first to be given study leave to go on specific courses. It leaves those who need it most left in the dark.
- N8:** I don't have the language to answer questions in a way that they [psychiatry] want, I mean some [nurses] have all the jargon. It makes you feel inadequate because you don't have the words and I feel a bit like 'Joe Soap' of the street the way they can tend to talk above you in way.
- N1:** It's not just the fact that I want to know why they've harmed themselves, it's the fact that...I know that psychiatry are under pressure and need to give their time to the patient and their family but if I'm their key nurse I don't want to be told from the parents that they're off home, I don't want to be just informed that 'yeah they're fine' and know just the practicalities of follow-up care, I want to be included.

IMPLICATIONS OF FINDINGS AND CONCLUSIONS

The aim of the study was to explore paediatric nurse's experiences of caring for young people who self-harm on a general medical ward. The purpose of the research was to capture what it is like for nurses with limited mental health training to care for patients who contravene not only societal norms but norms that underlie nursing care. This was considered in context of an evolving nursing model of care, which values a holistic approach.

A grounded theory methodology enabled the researcher to achieve this aim. The participants' narratives provided data, which reflected emerging themes and categories. The findings revealed one core category, 'Stepping on untreaded waters', which represented nurses' sense of uncertainty. This category related to four main categories which described: the use of support mechanisms; knowledge of self-harm; nursing culture; factors which influence a nurse's perception of being a 'good nurse'. The core and main categories were related to three principal categories: nurse training experienced; juggling the conflicting roles of patient care; a nurse's sense of being in the picture regarding a patient. These categories were formulated into a Model of Support Resources, which has implications for moving nursing knowledge and clinical practice forward. It suggests a means of supporting nurses who feel that they are 'Stepping on untreaded waters' progress to a place of security so that they feel they are 'Stepping on safer waters'.

Robinson et al. (2006) highlighted the role of policy documents such as the National Service Framework for Children, Young People and Maternity Services in providing nursing workforce planning initiatives to encourage staff recruitment and retention. They assert that expanding and developing the role of the paediatric nurse is essential to the modernisation of child health services. The present study illustrates the need for developing the role of paediatric nurses. It is apparent that nurses in this study are keen to develop their mental health knowledge base and acquire understanding and practical

skills to assist them to manage the care of young people who self-harm.

Estabrooks et al. (2005) argue that changes in nursing education have placed too great an emphasis on knowledge acquisition that is research based while devaluing experiential learning. Indeed, the gap between theory and practice has been acknowledged in policy documents such as *Fitness for Practice* (UKCC, 1999) which encourages a flexible approach that recognises nursing as a practice based profession. The present study highlights the challenges that nurses experience as a result of changes in nursing education. This has led to some nurses feeling undermined and unsupported which emphasises the need for nurses to have both formal and informal support mechanisms in place. Providing care to young people who self-harm without paediatric mental health training appears to further compound these negative feelings.

The nurses' narratives illustrated the importance of evidence based practice in patient care. For example, many nurses expressed the belief that allowing a young person to talk about their distress was helpful. Indeed, research supports this intervention (Hill, 1995). One participant recognised that talking allowed a young person to delay the act of self-harm. However, Huband & Tantam (2004) found that adults who have different patterns of self-harm behaviour find different approaches helpful. Those who experience a build up of pressure and follow a 'Springer' pathway can benefit from talking to a caring other. People who follow a 'Switcher' pathway reported that talking to someone about their distress was unhelpful when they felt the urge to self-harm. The authors noted that nursing staff generalised care approaches, believing that what was effective for one person was suitable for the next. This has implications for the present study, as nurses need to be made aware that certain approaches can actually be contraindicated for some people. Indeed, strategies that prove effective for an individual may not work the next time that same individual presents to hospital as there may be different triggers acting as a catalyst to their self-harm.

Another pertinent example of the importance of evidence based care was described involving a young person admitted to the ward as a result of self-harm having elastic bands removed from her wrists. Ryan et al. (1998) emphasised the danger of people failing to engage in healthcare services because of previous negative experiences. It is likely that this young person felt powerless without the use of an alternative coping mechanism. It is therefore crucial that nurses are made aware of all of the known triggers that can lead to self-harm. Many nurses recognised that this behaviour can lead to a sense of relief but it is also important that other factors, such as a young person's need for control, be made explicit. This may help nurses combat negative feelings that arise from a sense of having failed their patient by not stopping them from engaging in self-harm. This needs to be in an organisational context, with nurses being clear that they are not accountable for someone who engages in self-harm behaviour. In fact the stricter they are with the young person, the more likely the young person will be to find alternative means of self-harm.

One participant described an intervention which involved four nurses sitting around the bed of a young person justifying to her the reasons why they had to stop her attempting suicide on the ward. It was conveyed as a well meaning attempt on the nurses' part to try and cope with the young person's state of withdrawal. Abuse is a known risk factor for self-harm, whether it is sexual, physical or emotional abuse. Abusive relationships represent unequal power differentials in relationships. If this young person had experience of an abusive relationship, where someone had power over her, this intervention, however benign, may have mirrored this relationship and been perceived as threatening. This group intervention appeared to be based on the premise that they were supporting each other through a traumatic time. This highlights the need for formal support mechanisms to be in place.

In addition, some participants revealed the belief that patients who self-harm have a poor prognosis, particularly if the person repeatedly self-harms; as found in other research

(House et al., 1998). There did not appear to be a means of communication for nurses to learn that young people can and do learn to cope without self-harm. Perhaps the use of real life vignettes and quotations in self-harm training could help to instil a sense of hope in nurses who feel that their time is not well spent on a patient who is perceived as helpless.

I gradually realised that it did not solve any of my problems. Also my mood lifted slightly and I no longer felt the compulsion so strongly.

(young person quoted in Truth Hurts, National Inquiry, 2006:73)

Ruttle & Chappell (2006) found that there was a need for improved communication among professionals in a child and adolescent mental health service managing the care of clients who self-harm. The pervading sense of uncertainty experienced by nurses in the present study must be challenged and channels of communication need to be opened to allow this to occur. Anderson et al. (2004) described the benefits of a ward having a nurse consultant to help facilitate links between teams. This position would appear advantageous to nurses in the current study. One participant talked about the value of knowing a member of the team in DCFP which increased her willingness to seek advice when needed.

There was a clear sense that nurses want to learn more about self-harm to increase their confidence dealing with this problem but there are barriers, such as a lack of time and resources, which impact on this goal. There needs to be a way to disseminate information efficiently among staff, such as designated people offering feedback sessions after courses have been attended.

Participants talked about experiencing negative attitudes, beliefs and behaviours of other healthcare professionals towards young people and adults who self-harm. The example of the nurse who defended the young girl to a surgical team who were making derogatory

remarks about her highlighted the benefit of empowering an individual with knowledge so that they feel more confident to challenge negative attitudes and act as a patient advocate. It also highlights the need for further research into the experiences of other healthcare professionals caring for this patient group. If a nurse's value system (Rayner et al., 2005) can be challenged by a patient who self-harms, what is the impact of this patient's behaviour on a surgical team who have no sense of context of the person's life story and have no opportunity to establish a relationship?

Thompson (2006) states that when introducing new initiatives in a health care setting interpersonal contact increases the likelihood of staff demonstrating behavioural change. The present findings indicate the use of avoidance strategies to cope with uncertainty. Avoidance strategies need to be combated to allow nurses to learn that they have valuable skills to offer this group of patients. Interpersonal contact is needed to help facilitate this process whether that is through peer support or role modelling. It also needs to be set in a context of education and training which is delivered in a sensitive manner that takes into account the evolving face of nurse education. It is important to recognise contributions from traditionally trained nurses, as well as acknowledging the benefits of evidence based care as illuminated in the above examples. A relatively easy to implement strategy highlighted during the member check session was the use of praise from senior nursing colleagues to acknowledge efforts made in a setting that is not conducive to meeting these young peoples' needs.

Some suggestions were made by nursing staff which have implications for practice. Recommendations made by nurses themselves are more likely to resonate with staff and increase the likelihood of being accepted into nursing culture. One participant expressed the value of short teaching sessions on mental health issues. This is supported in the literature as an effective way of meeting the educational needs of medical staff (Crawford et al., 1998). A nurse also commented on the tendency of experienced nursing staff to protect junior nurses from patients who self-harm. She highlighted the need to

increase exposure and recommended work experience in the Accident and Emergency departments on weekend nights. Another nurse stated that all nurses should gain experience working in DCFP, she acknowledged that it may be difficult to implement but highlighted the need for practical experience of a different nature to gain insight into the issue that affect young people who self-harm.

The attempted suicide on the Children's Ward in 2004, mentioned above, led to NHS Highland commissioning an external review group to explore care provision for young people experiencing mental health problems. The report that was generated as a result is not in publication but the researcher acquired permission to state that one of the guidelines suggests 'protocols regarding supervision and training should be in place for all staff'. Considering the participants interpretation of the word supervision, it would seem paramount to ensure any guidelines drawn up explain the aims of this process to avoid confusion.

The main finding of the present study relates to a nurse's sense of uncertainty when managing the care of a young person who self-harms. The explorative nature of this work gave nurses the opportunity to speak openly about the difficulties encountered and the negative emotions evoked. It is imperative that nurses working without mental health training are supported in their role to care for young people who self-harm in a way that meets their needs. Self-harm is an emotive issue and one that is likely to place growing demands on healthcare services. As such, staff need to be able to meet these demands in a way that makes them feel safe in their role and confident to provide the care needed by young people who self-harm.

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APPENDIX 1

Nurse information sheets

Participant Information Sheet

Exploring the experiences and attitudes of paediatric nurses working on a children's ward with regard to adolescents who deliberately self-harm.

You are invited to take part in a research study because you are working as a paediatric nurse in Raigmore Hospital. Before you decide, it is important for you to understand why the research is being carried out and what will be involved.

Thank you for taking the time to read this

Background

There is evidence to suggest that self-harm evokes strong emotions in others. The principals of nursing care are motivated by efforts to relieve pain and illness. Research suggests that a number of nurses find it difficult to work with patients who deliberately cause their own injuries, as they deprive patients with more 'legitimate' illnesses of nursing time and energy. This can result in nursing staff understandably experiencing professional feelings of ineffectiveness and increased stress levels. On the other hand it can and often does evoke strong feelings of concern and empathy towards the young person.

The present study

This is a project into the views and experiences relating to patients who deliberately self-harm, of both newly qualified nursing staff (classed as those working three years or less) and those with fifteen years or more paediatric experience. The aim is to recruit 6-8 nurses for each group.

There is no obligation to partake in this study and you can withdraw without explanation at any time. All information will be kept strictly confidential except if you or another person known to you is perceived to be at risk of harm. If you decide to take part, you will be asked to sign a consent form.

A discussion time will be arranged at your convenience, which will last approximately 45 minutes. The conversation that takes place will be audio-recorded and transcribed so that common themes can be identified and compared with interviews with others. All information will be kept strictly confidential and only the researcher will have access to it. If you have any concerns or queries regarding this study please feel free to get in touch.

This study will begin in January 2006, and will be completed and written up by August 2006. The results of the research will be written up for submission towards a Doctoral qualification in Clinical Psychology awarded by the University of Edinburgh. You will not be identified or be identifiable in any report or publication. The Highland NHS Board Ethics Committee has reviewed this study.

Contact details: Tracy McGlynn, Trainee Clinical Psychologist, Clinical Psychology Service for Children and Young People, The Alligin Centre, Larch House, Stoneyfield, Inverness, IV2 7PA. Telephone: 01463 704 665 Email: tracy.mcglynn@hpct.scot.nhs.uk. My supervisor, Dr Chrissy Munro, Clinical Child Psychologist can also be contacted at the same address and telephone number as above if you have any concerns regarding the way the study is being carried out.

APPENDIX 2

Nurse questionnaire

My name is Tracy McGlynn. I am a Trainee Clinical Psychologist working in the Psychology Service for Children and Young People in Inverness. I'm hoping to carry out a study interviewing nurses about their perceptions and experiences of dealing with deliberate self harm on a children's ward.

It would consist of a one-off interview. It would be completely confidential and no information given would be identifiable to you.

If you would consider participating please complete this short form and I will contact you on the ward to arrange a time to meet. I can be contacted on 01463 704665 if you have any queries regarding this study.

Your name

Approximately, how long have you worked as a paediatric nurse?

Have you completed any secondments in a psychiatric workplace(s)? If yes, please give details.

Have you attended any relevant courses in paediatric mental health? If yes, please give details.

Are you interested in learning more in this area?

Thank you for your time. It is much appreciated.

Please return the questionnaire in the envelope provided via internal mail

APPENDIX 3

Research protocol

Research Protocol

A qualitative study of paediatric nurses experiences and perceptions of adolescents who deliberately self-harm as well as those patients personal experiences of staying on a children's ward.

The aim of the study is to explore experiences and perceptions of paediatric nurses towards adolescents (11-16 years) who deliberately self-harm. It is expected that nurses' attitudes towards adolescents who deliberately self-harm will be reflected through their behaviour towards the young person. Hence, it is invaluable to also look at adolescents' perceptions of their own personal experiences of spending time on a children's ward as a result of their self-harm.

It is not possible to compare an adolescent's experience of being on a children's ward with an individual nurse of a particular level of experience, as the adolescent is likely to be cared for by many different nurses during their stay on the ward. However, the literature suggests that a shared negative belief system may exist among hospital staff because deliberate self-harm goes against the very philosophy underpinning health care, that is, to heal people. Medical staff's ability to heal is impeded by the person who intentionally harms them self and "wastes" valuable medical time and resources (Rayner et al, 2005).

The Grounded Theory approach will be used with the nursing population in an effort to gain a range of perspectives to see if common themes arise. Categories generated will be compared to the existing body of research in this area.

In a Grounded Theory study, data collection and analysis takes place in alternating sequences. The process of analysis involves a series of coding procedures which starts with the first interview, which thereafter leads to the next interview with the next participant, followed by further analysis, then more interviews with other participants.

Each interview builds from and adds to the data which has been previously collected and analysed. Themes, new issues and questions emerge which direct the researcher to new sources of data. Initially, the researcher's aim is to produce as many themes/categories as possible, therefore data is collected in a range of relevant areas. Data is collected until no new data is being discovered. This stage is known as the saturation point.

The theory generated is grounded in the data which has been collected from the research participants, and the emerging concepts and categories should closely reflect their construction of their social world.

The interviews will be unstructured but with some general guidelines, for example the nursing interview will begin with a single and open question such as "I am interested in Deliberate Self-Harm and what it means to you to take care of adolescents who stay on the ward that are known to engage in this behaviour?". This type of question is intended to encourage respondents to open up. Questions which begin with the following phrases; "Tell me what you think about...?", "What happened when....?", and "What was your experience with..." are deemed useful in this approach. These

types of questions give respondents more scope to respond in terms of what is relevant to them. (Strauss & Corbin, 1998).

A useful feature of unstructured interviews is that it allows participants the opportunity to tell their stories from the beginning to the end. It is considered a very good source of information for a Grounded Theory approach, where it is important to understand the order of the events so that the process can be clearly understood (Morse & Field, 1996).

The interviews normally take the form of open-ended questions initially as the researcher listens to their stories. As the research progresses, interviews are guided by the developing theory, and the researcher may ask direct questions relating to the emerging categories. Therefore, there is no standard interview schedule.

The same approach will also be used with adolescents to gain an understanding of their perceptions of their own experiences on the ward and of the meanings those experiences hold for them. A single open question like "Can you tell me what it was like to stay on a children's ward?" will be asked.

Time will be spent building up a rapport prior to all interviews. It may help to facilitate the interview process if adolescents are encouraged to convey their perceptions in a written or pictorial form prior to meeting, which can then be explored further through discussion.

Approximately 8-10 nurses of various levels of experience will be interviewed. The researcher also intends to interview approximately 8 young people who have spent time on a children's ward. The one-off in-depth interview will be recorded and transcribed for analysis. Results will be provided to nursing staff to highlight positive interactions and provide information on what has been experienced as most and least helpful by young people. The information gathered may help participants see that their experiences are familiar to others, for example they may not be alone in experiencing difficult emotions in similar circumstances. The research will also help inform newly qualified nurses of possible emotions that may arise in their future work. A summary of the results will be provided to any participant who requests it.

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Trainee Clinical Psychologist
Clinical Psychology Service for Children
And Young People
The Alligin Centre
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IV2 7PA

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APPENDIX 4

Information sheet, participant consent, parent/guardian consent form and letter to parent/ guardian

Do you want your say?

More and more young people are being asked their views about what is helpful and not so helpful about the care they receive when in hospital.

You are being asked to take part in this project because you have spent time on a children's ward. I would like to chat to you about your personal experience there. Your comments will be kept strictly confidential, so you can say what you like! (The only exception to this would be if it was thought that the safety of you or someone you know was at risk, but this would be discussed with you first before having to tell someone who could help).



Many people do not know the reasons why someone self-harms. Some TV programmes, like *Hollyoaks*, have brought this issue out in the open, but there is still a lot to learn. Some people think it's about getting attention. This is rarely the case. However, it can lead to others being less understanding and sympathetic, if they believe this to be true.

I am interested in hearing from you what was helpful and not so helpful about being on the ward. I would also like to chat to you about some of your thoughts and feelings of this experience.

If you would like to take part, please return the completed consent form in the stamped addressed envelope provided. Please ensure your parent/guardian also signs this form before returning it. I will then contact you to arrange a time and place that would suit you to meet. If you have any questions or concerns please feel free to get in touch.

I hope to chat to you for about 30-45 minutes. I will tape our conversation and then type it out so I can pick out themes and see if other young people I interview have similar experiences. In no way will you be identified from any information you give me. This study forms part of my course to qualify as a Clinical Psychologist. A summary of the results will be provided if you are interested.

Some people find it easier to write down or draw something that helps describe their experience. Feel free to bring something along that you have created.

Contact details: Tracy McGlynn, Trainee Clinical Psychologist, Clinical Psychology Service for Children and Young People, The Alligin Centre, Larch House, Stoneyfield, Inverness, IV2 7PA. Telephone: 01463 704665 or Email: tracy.mcglynn@hpct.scot.nhs.uk. My supervisor Dr Chrissy Munro, Clinical Child Psychologist can also be contacted at the above address and telephone number.

Young Person's Consent Form

I consent to participate in this study. I understand that the interview will be audio-taped and that all information I give will be kept strictly confidential and nothing I say will be identifiable to me. I am free to withdraw from the study without explanation at any time.

Name:

Signature:

Phone number:

If you have an answering machine, is it ok to leave a message on this number?

I would like a summary of the study when it is completed: YES NO
(Please circle your responses. If you answered no, there is no need to provide your address below)

Address:

Parent/Guardian's Consent Form

I consent for the above named child to participate in this study. I understand that the interview will be audio-taped and that all information given will be kept strictly confidential and nothing my child says will be identifiable to him or her. I am aware that he/she is free to withdraw from the study at any time without explanation.

Name:

Signature:

Relationship to child:

Phone number:

If you have an answering machine, is it ok to leave a message on this number?

I would like a summary of the study when it is completed: YES NO
(Please circle your responses. If you answered no, there is no need to provide your address below)

Address:

If you have any questions or concerns regarding this study or you have experienced upsetting thoughts as a result of participating in this study I can be contacted on 01463 704665 or Email: tracymcglynn@hpct.scot.nhs.uk

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Date: 5th March 2006
Our Ref: TMcG/SR

Enquiries to: 01463 704665

Dear parent(s)/guardian

I am a third year trainee clinical psychologist at the University of Edinburgh. I work in the Clinical Psychology Service for Children and Young People in Inverness.

As part of my final year, I am carrying out a research project looking at the personal experiences of young people who have spent time on a children's ward as a result of their self-harming behaviour.

The aim of this study is to explore what your child found helpful and perhaps least helpful about their stay on the ward, as well as their feelings and attitudes about their experiences there. All information gathered from your child will be kept in strictest confidence.

If your child is willing to participate and you are in agreement, please complete the attached consent form and place it in the stamped addressed envelope provided. There is no obligation to participate in the study and your child is free to withdraw without explanation at any time. In no way will participating or not participating in this study affect the mental health services your child already receives.

If you agree, I will make contact to arrange a suitable time and place to meet your child. I hope to spend 30-45 minutes speaking with them. I will tape and transcribe our conversation so that I can identify themes and see if other young people have similar experiences. A summary of my findings can be obtained when the work is completed.

I look forward to hearing from you. Please feel free to contact me if you have any queries or concerns regarding this study. You can also speak with your child's mental health worker if you wish to discuss any issues you have concerning your child's participation in this study.

Yours sincerely

TRACY McGLYNN
Trainee Clinical Psychologist

DR CHRISSY MUNRO
Clinical Child Psychologist
Supervisor

Working with you to make Highland the healthy place to be



Chairman: Mr Garry Coutts
Chief Executive: Dr Roger Gibbins BA MBA PhD

NHS Highland, Assynt House, Beechwood Park, INVERNESS IV2 3HG
Highland NHS Board is the common name of Highland Health Board

APPENDIX 5

Summary of participants

No.	Gender	Length of time since qualification	Psychiatric secondments	Mental Health courses	Interested in receiving MH training
1	Female	>10yrs	Yes	Yes	Yes
2	Female	>10yrs	No	No	Yes
3	Female	<5yrs	Yes	Yes	Yes
4	Female	>10yrs	Yes	Yes	Yes
5	Female	<5yrs	Yes	Yes	Yes
6	Female	<5yrs	No	No	Yes
7	Female	<5yrs	No	No	Yes
8	Female	>10yrs	Yes	Yes	Yes

Details of psychiatric secondments undertaken, courses attended and exact length of time since qualification have been omitted to maintain participants' anonymity.

APPENDIX 6

Consent form

Consent form for all participants to allow interview to be audio-recorded

I agree to my interview being recorded on tape and the contents written out so that the researcher can use this information to compare it to experiences of other people contributing to this study. I understand that all information I give will remain anonymous and will not be identifiable to me.

Name:

Signature:

Date:

APPENDIX 7

Interview guide

Interview Guide: General Themes

- ☐ Nursing career – specialist placements experienced.
- ☐ First recollection of caring for someone who self-harms.
- ☐ Other nursing experiences of caring for someone who self-harms.
- ☐ Feelings evoked as a result.
- ☐ Nurses' management of their own emotional responses.